Investigating motivations and barriers to working with older people among psychologists in clinical training in the UK

Thesis

UNRESTRICTED

Kristina Lee

Investigating motivations and barriers to working with older people among psychologists in clinical training in the UK

A thesis submitted in partial fulfilment of the requirements of the Open University for the degree of Doctor of Clinical Psychology

SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY COLLEGE

SEPTEMBER 1999

Approximate word count: 20,000

AWARD DATE: 22 September 1999

DECLARATION FOR DISSERTATION

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed ...Tina Lee..... (candidate)

Date ...13.7.99.....

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

Signed .....Tina Lee..... (candidate)

Date .....13.7.99.....

Signed ..... P.J. VOLANS ..... (supervisor)

Date .....11/7/99.....

STATEMENT 2

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and abstract to be made available to outside organisations.

Signed .....Tina Lee..... (candidate)

Date .....13.7.99.....

Acknowledgements

There are a number of people that the author would like to thank for their assistance with this research. Primarily Dr. Jane Volans for her excellent advice and support at every stage. Her knowledge, experience and understanding have been invaluable. Secondly the clinical psychology trainees who gave their time, even though this was precious, and their thoughtful ideas; without them this research would not have been possible.

Thirdly, several of the course staff from Salomons: Dr. Sue Holttum for her statistical advice, support and availability throughout the project; Meg Rolleston and Michael Maltby for helping me think over my initial ideas and Stephen Boddington for agreeing to be available to debrief trainees.

Fourthly Nicky Gregory for her time, energy and kindness.

Lastly Paul Crawt for his ongoing love and support.

Abstract

Background and Aims: The population aged over 65 in the UK is increasing, however this population is traditionally underserved by clinical psychologists. Part of the reason for this underservice may relate to psychologists' reluctance to work with this group. The literature suggests a number of issues which may account for this reluctance, e.g. professional ageism, anxiety about ageing, death and dependency. This research aims to explore the relevance of these issues among clinical psychology trainees, as well as exploring their attitudes towards psychotherapy with older clients and their thoughts about how recruitment could be improved.

Design and Participants: A cross sectional postal design was used. Questionnaires were sent to trainees at 25 of the Clinical Psychology Training courses in the UK. Three hundred and seventy-one trainees returned questionnaires.

Measures: A questionnaire was designed by the author which included a number of published measures.

Results: The trainees reported that they were less interested in working within the older adult specialty than within the adult or child specialties, although older adult services were more popular than learning disability services. The trainees' interest in working with older people could be predicted by their interest in this area prior to training; by aspects of their ageing anxiety and by their experience of working with older people during training. The trainees' age; death anxiety and attitude to older people did not predict their interest in this area. Trainees further discussed how they thought approaches should be modified with older people; why they thought recruitment to this area may be problematic and how recruitment could be improved.

Discussion and Implications: The discussion considers provisional explanations for the findings. The clinical implications are examined particularly in terms of recruitment to the older adult specialty. The limitations with this study are explored and ways forward suggested.

Table of Contents

List of Tables

List of Figures

Introduction

One of the major problems currently facing human service professionals is caring for the ageing population and with increasing numbers of older adults[1] these difficulties are likely to be magnified (Compton, 1989). The relative proportion of older adults in most western societies has increased significantly over the past decade, particularly those persons aged 85 and over (Litwin, 1994). In 1995 18.2% of the population was over retirement age (60/65+) in the UK and 7% were aged 75 years and over (Government Statistical Service, 1999). The next century with the post-war 'baby-boom' generation reaching 65 from the year 2011, promises a further increase in the overall elderly population in western societies (Britton & Woods, 1996). It has been suggested that soon over a third of the population will be over 65 years of age (Jones, 1999).

Additionally the prevalence of psychological disorders is thought to increase with age and individuals over 65 face an augmented risk for developing mental illness (Butler & Lewis, 1977; Greene, 1986). Evidence suggests 25-40 percent of GP patients over 75 have a psychological problem of some kind detectable by the GHQ (Bowling, 1990; Goudie & Richards, 1993). Furthermore, following a review of the literature, Martin, Fleming & Evans (1995) reported that the "development of depression in elderly subjects is associated with a higher risk of suicide than for any other age group" (p.999). Similarly, an earlier study from the USA noted that 20% of all suicides were committed by individuals age 65 and over (Butler, 1985).

---

[1] Throughout this report the terms older people, older adults and older clients will be used to refer to people over 65 years of age. However it is important to stress that the age of 65 is an arbitrary cut-off point commonly used within mental health services to determine which services people should access. It encompasses a broad cohort of 30 or so years and a diversity of life experiences and life stages, so generalisations must be treated cautiously. This cut off point in itself could be described as ageist (Howells, 1992). Bytheway (1990) emphasises the irony that: "gerontologists are dangerously inclined to live a double life ... in which they simultaneously deplore ageism and build their 'careers' upon the study of 'elderly people'" (p.17).

There is no reason to believe that older adults' need for mental health services is significantly less than that of other age groups (Kay & Bergmann, 1980), in fact the opposite may be true. However older people are traditionally underrepresented in both mental health services (Edinberg, 1985) and psychology services (VandenBos, Strapp & Kilburg, 1981). A recurring problem for clinical psychologists working with older people is determining why this burgeoning population does not make use of psychology services, especially in light of the extent of their mental health problems (e.g. Dye, 1978).

It has been suggested that older adults' emotional and mental health problems have to a large extent been neglected (Butler, 1975). Clinical psychologists would seem to be equally culpable in this respect as other professionals. Statistics from the USA suggest that while 15 to 20 percent of older adults need mental healthcare (Gurland & Cross, 1982), only 2.7 percent of those over 65 years of age receive services from psychologists (Santos & VandenBos, 1982). In the UK, despite the fact that the average person over 75 consumes five times the national per capita average of NHS resources (Furnish, 1994), older people are proportionally less likely to make initial contacts with a clinical psychologist than any other age group (Gilleard, Askham, Biggs, Gibson & Woods, 1995). In 1992/1993 less than 10% of initial contacts with clinical psychologists were aged 65 and over, although older people formed 16% of the total population (Department of Health, 1994).

A whole range of impediments have been suggested which may prevent adequate delivery and/or limit the utilisation of mental health services to older persons (Butler and Lewis, 1977; Ford & Sbordone, 1980). Older people themselves may be reluctant to use mental health services (Kucharski, White & Schratz, 1979) and may fear being labelled 'insane' (Ford & Sbordone, 1980) or weak (Scher, 1981). Roybal (1988) suggests that many older adults are reluctant to admit to problems and prefer to deal with them on their own. Furthermore, it has been argued that older people tend not to express their difficulties in psychological terms (Goudie & Richards, 1993) and perhaps as a result, family physicians are less likely to refer older people to secondary/tertiary care (MacDonald, 1986; O'Connor,

1988). Recognising mental health problems among older people may be problematic, e.g. a recent study by Garrard, Rolnick, Nitz, Leupke, Jackson et al. (1998) found that only half of older adults with self reported depression had documented clinical detection of depression by health providers. Additionally physical and mental malfunctions may be seen as the inevitable burden of old age (Rabins, 1996) making referral to mental health services unlikely.

There are many possible reasons why older adults are less likely to see psychologists; however this research intends to investigate the impact of the dearth of clinical psychologists working in this specialty. Under-recruitment of clinical psychologists to work with older people has been a recurrent problem (Britton & Woods, 1996), even though there have recently been a number of developments within older adult psychology. During the early 1970s clinical psychologists' work with older people was almost entirely confined to assessment (Britton & Woods, 1996). However the opportunities for applying psychology to the needs of older people have increased dramatically in the second half of the 20th century (Britton & Woods, 1996).

Alongside this development there has been *some* increase in the number of psychologists working with older people in the UK over the last two decades (Gilleard et al., 1995). However although much has been achieved, the potential has often not been fulfilled, "largely because funding, training and recruitment have not been able to keep pace with the demand for psychological inputs to a wide range of services for older people" (p.1, Britton & Woods, 1996). Due to a lack of applicants, a number of posts for clinical psychologists working with older adults have been frozen or lost; as a result there was a steep decline in the number of older adult posts advertised and a "chronic shortfall in the specialty" (p.11, Garland, Lewis and Pimm, 1989). Nineteen per cent of all elderly posts were vacant in 1986, compared to only 6% in child services (Hall, Koch, Pilling & Winter, 1986).

A number of reasons have been suggested for the existence of under-recruitment to older adult services. Significantly, clinical psychologist have been found to be less interested

in working with older people than younger age groups (e.g. Dye, 1978). A recent survey estimated only 6% of the 220 clinical psychology trainees qualifying each year would go on to work with older people (British Psychological Society, 1995). This situation has also been seen in other countries. Poor recruitment of psychologists into this specialty has been reported in America (James & Haley, 1995) and Israel (Smotkin, Eyal & Lomranz, 1992). Over the last forty years many articles have been written decrying the situation (e.g. Oberleder, 1966; Rechtschaffen, 1959), yet the figures remain the same.

This reluctance to work with older people has been reported in other professional groups, older adults are not the favourite clientele among many health care providers. A survey conducted by Wolk and Wolk (1971) reported 80 percent of professionals preferred not to work with the aged. Negative attitudes to working with older people have been found in a number of disciplines, including nurses (Haight, Christ & Dias, 1994), physicians (Saarela & Viukari, 1995), medical students (McAlpine, Gilhooly, Murray, Lennox & Caird, 1995), social service personnel (Litwin, 1994) and physiotherapists (Mount, 1993). Studies of social work trainees in the United States have consistently found work with older adults to merit a relatively low priority among respondents (Abell & McDonnel, 1990; Butler, 1990).

Victor (1994) argues that 'geriatrics' has been seen as a 'low status' specialty. Moreover there may be the belief that scarce resources of time, energy and money should be expended on younger clients and not those close to death, to whom long term benefits would be less likely (Dye, 1978). Moreover work with older people may be devalued because the conditions are often seen as chronic with a lack of glamorous, high technology treatments (Busse & Blazer, 1980). Professionals' reluctance to specialise in mental healthcare for older people has been thought to contribute to a vicious circle of limited resources and limited expectations (Gilleard et al., 1995).

A number of factors have been proposed as influencing clinical psychologists' and other mental health professionals' reactions to working with older people. These include

ageism, attitudes to psychotherapy[2] with older adults and countertransference issues; these issues will be discussed in the following sections.

Ageism

It has been suggested that much of the discriminatory practice in health services and the high vacancy rates for psychologists within the older adult specialty result from ageism (Gilleard et al., 1995). "Psychologists are the products of the society in which they live and work. As with other forms of bias, ageism is inherent in many ways in our society and can influence one's perceptions and assumptions in subtle and overt ways" (Schaie, 1993, p.49).

Butler (1975) defined ageism as "a systematic stereotyping and discrimination against people solely on the basis of their 'old' age". He continues:

> *"Ageism allows those of us who are younger to see old people as 'different'. We subtly cease to identify with them as human beings, which enables us to feel more comfortable about our neglect and dislike of them....Ageism is a thinly disguised attempt to avoid the personal reality of human ageing and death" (Butler, 1975, p.893).*

It is common in Western culture to distance oneself from the very old, assuming they do not know and do not notice, and consequently do not suffer (Arie, 1981). According to de Beauvoir (1977), if old people show the same feelings, desires and requirements as the young, they are looked upon with disgust: "in them love and jealousy seem revolting or absurd, sexuality repulsive and violence ludicrous".

---

[2] The term "psychotherapy" unless otherwise indicated is used to refer to a range of approaches including cognitive-behavioural therapy (CBT), systemic therapy, psychodynamic therapy and such techniques as reminiscence therapy and reality orientation.

Prejudiced ways of looking at others tend to ignore diversity, rendering 'them' as homogenous (Slater, 1995). Part of the process involves the perception of attributes and what has been termed the 'fundamental attribution error' (Brown, 1986); this being the tendency for an observer to overestimate dispositional causes and to underestimate situational causes for the observed behaviour. Stereotypes may have a kernel of truth in them, but this may get over-generalised indiscriminately (Slater, 1995). Shura (1974) concludes that society needs a balanced view of people growing old, with a clear understanding of both their needs and their assets.

Giles & Coupland (1991) suggest young people construct negative identities for the old as: "depressed and depressing, and as dull, grouchy and unreliable conversationalists" (p.163). Dixon & Gregory (1987) point to a number of unhelpful myths associated with old age:

- the myth of ill heath - old age automatically involves physical deterioration and illness in old age is part of normal ageing, not the result of disease;
- the myth of mental deterioration - older people automatically lose their mental faculties, slow down and become 'senile';
- the myth of inflexible personality - personality changes with age to become more intolerant, inflexible and conservative;
- the myth of misery - elderly people are unhappy because they are old;
- the myth of unproductivity and dependence - older people are not productive members of society because they are not engaged in paid employment and are inevitably dependent on others.

Professional Ageism

Butler and Lewis (1977) consider professional negativism regarding the older client as manifestations of "professional ageism", they list the following issues:

1. The aged's stimulation of therapists' fears regarding their own old age
2. Therapists' conflicts about their own parental relations
3. Felt impotence stemming from a belief in the ubiquity of untreatable organic conditions in the elderly
4. Desire to avoid 'wasting' skills on persons nearing death
5. Fears an aged patient may die during treatment
6. Desire to avoid colleagues' negative evaluation of efforts directed towards older people

Britton & Woods (1996) emphasise that psychologists are not immune to the fears and apprehensions identified by Butler & Lewis (1977) as underlying the use of ageism as a defensive manoeuvre. As Knight (1996) points out "many of life's most difficult problems are represented in the aged population and the fact of possibly having to face those problems oneself arouses a different level of fear" (p.70). He continues that Western society has a tendency to avoid thinking about these aspects of life and therapeutic work with older people confronts the therapist with these issues in a very personal manner. Talking about the time before we were born reminds us that we were not always here, just as talking about dying reminds us that we will not always be here (Knight, 1996). The therapist may be forced to confront the finitude of life earlier than is normal or may have personal anxieties reinforced by close contact with those near death (Knight, 1996). These issues will be further explored in the section on countertransference issues.

Recently researchers have become interested in the effect of professionals' age-related attitudes to the elderly (e.g. Bachelder, 1989; DePaola, Neimeyer & Ross, 1994; Gardner & Perritt, 1983). Such attitudes have been studied in various settings (Busse, 1987; Harper, Manasse & Newton, 1992; Ingstad & Götestam, 1987). Ageist beliefs are known to be associated with discrimination in healthcare services (Furnish, 1994) and the existence of age discrimination in medical and psychiatric care has been well documented (Gilleard et al., 1995). Despite efforts to eliminate stereotypes about ageing, many misconceptions have

remained (Greene, 1983). Saarela & Viukari (1995) suggest that these negative attitudes could lead to recruitment problems and even shortcomings in treatment. They further argue that negative attitudes can predispose to negative identification: "treating an old person as 'a loser' makes the professional 'a loser' also" (p.799).

Lack of appropriate training may be significant in promoting ageism. Victor (1994) suggests that the education of health care professionals in the health care of the elderly is limited. West and Levy (1985) found that physicians in specialty areas that more frequently serve the old were no more knowledgeable about ageing than paediatricians. A feature of the education is a concentration on the pathological aspects of ageing, rather than an investigation of 'normal' ageing. She further suggests that this educational bias probably provides at least partial explanation as to why the old are perceived so negatively by many members of the medical and allied professions.

However, the prevalence of ageism among mental health professionals is controversial (Schonfield, 1982). Indeed Gatz and Pearson (1988) suggest global negative attitudes towards the elderly have not been borne out. They suggest the presence of age bias among clinicians has been overstated and may be non-existent. Furthermore, following a review of the relevant literature, O'Leary (1995) concludes the picture emerging is one of generally positive feelings about working with older adults, although the age of the professional is an important mediating factor. For example, Mutschler (1971) studying gerontological social workers found that those who preferred to work with older people tended themselves to be older than those who chose not to work with older persons.

Investigations of the attitudes of students and professional psychologists towards the elderly are rare (Ray, McKinney & Ford, 1987). Dye (1978) found psychologists mentioned negative aspects of the ageing process as a reason for giving older clients lower preference. On the other hand, Knight (1985-86) suggests that although there is a widely held belief that therapists avoid work with older adults because of negative attitudes towards them, there are

no empirical data supporting this hypothesis and he argues that the role of therapists' negative attitudes has been exaggerated.

In terms of trainee psychologists, Britton & Woods (1996) argue that most trainees bring to their courses their own version of the common stereotypy and mythology surrounding the older person. Many supervisors have experienced trainees who seem to suffer from a form of 'client shock' or 'setting shock' in the initial few weeks of a placement (Britton & Woods, 1996). They suggest that the roots of this shock may be in the individual's poor awareness of the realities of the older person and their care settings, of their potential and their needs.

The literature reveals conflicting opinions as to the extent and relevance of ageist attitudes and their effects on the availability of services for older people. Furthermore there have been few studies of trainee psychologists' attitudes to older people and how this interacts with their motivation to work in the older adult specialty.

Attitudes to psychotherapy with older people

Mental health professionals have been described as "reluctant therapists" with reference to working with older clients, a term initially coined by Kastenbaum (1963). It has been suggested that this reluctance may relate to a general pessimistic attitude to psychotherapeutic work with older people. Pessimism about working with older adults can be traced back to Freud (1905/1953) and the psychoanalytic assumption that older people had character structures too rigid to permit change:

> *"....near or above the fifties the elasticity of the mental processes, on which treatment depends, is as a rule lacking - old people are no longer educable - and on the other hand, the mass of material to be dealt with would prolong the duration of the treatment indefinitely" (p.264).*

Greene (1986) argues that Freud's legacy of scepticism as to the value of psychotherapy for the aged has long influenced the delivery of psychiatric services for this population group. She continues that therapy with the aged is often viewed "as only supportive", "a second rate procedure", "having no systematic theory" or "not worth a long-term investment" (Butler & Lewis, 1977; Cohen, 1977; Mutschler, 1971). This is highlighted by the fact that until 1986, the British Psychoanalytic Society, the official institution governing psychoanalysis in Great Britain refused to accept patients over the age of fourty (Hildebrand, 1986).

Many therapists continue to believe psychotherapy is unsuitable and inefficient in old age (Ford & Sbordone, 1980; Kastenbaum, 1978; Ray, Raciti & Ford, 1985) and diagnoses of older people often reflect pessimism about psychotherapeutic improvement (Settin, 1982). Sprung (1989) argues that some mental health workers still believe the problems of older people are insoluble and are related to senility and/or irreversible brain damage. Butler (1980) estimated that 10 to 30% of all treatable mental disorders in older people are misdiagnosed as untreatable. Moreover older adults, like their doctors, may all too readily attribute many correctable conditions to what they consider to be the normal ageing process (Sparacino, 1978).

Further studies from the USA have suggested that when older people are seen by psychiatrists they most frequently receive consultation regarding institutionalisation rather than psychotherapy (Butler, 1975; Marmor, 1975). Psychiatrists have been found to regard older patients as less satisfactory for treatment than younger patients with identical symptoms (Ford & Sbordone, 1980). Cyrus-Lutz & Gaitz (1972) reported that boredom and resentment towards the physical and mental deterioration of older clients were prominent features of psychiatrists' attitudes towards the aged.

Negative stereotypes about ageing and about elderly persons may prevent mental health professionals from reaching out to older clients in the erroneous belief that therapeutic efforts are likely to be difficult or unproductive (Roybal, 1988). Dye's (1978) study of 1400 clinical psychologists in America found that younger clients were perceived as best able to respond to the therapeutic situation. Many believed older persons were more rigid, unable to learn as readily and had less energy available for therapeutic growth.

However more positive attitudes to working with older people have also been reported. Knight (1996) argues that although Freud's early dictum is often sited as a basis of therapeutic pessimism, few modern therapists would seriously consider people of around 50 years of age to be no longer educable. He argues that that the presumed pervasive pessimism about therapy with older people has not been universally supported by therapists.

Furthermore there are a number of accounts in the literature of positive outcomes from psychotherapy with older clients. In an early review of psychotherapy with older adults, Rechtschaffen (1959) presents a generally optimistic portrayal, although he left open the question of whether psychotherapy with older people requires modification. Abraham (1919/1953) cautioned against preconceived notions of treatment with older adults, he argued that "the age of the neurosis is more important than the age of the patient" (p.317). Butler (1963, 1968) points out that the possibility for intrapsychic change may be greater in old age than at any other period in life. The very proximity to death is a factor motivating the individual to get on with the process of integrating life experiences (Dye, 1978; Nemiroff & Colarusso, 1985). Meerloo (1955) indicated that old age can be a time of ripe experience and inner wisdom. The approach of death leads the older adult to life review/evaluation and decreased defensiveness, allowing easier access to the patient's unconscious (Meerloo, 1955b).

There is increasing evidence that older clients respond positively to individual psychotherapy regardless of orientation (e.g. Arean et al., 1993; Orbach, 1996; Scogin &

McElreath, 1994; Thompson, Gallagher & Breckenridge, 1987). Zarit & Knight (1996) report growing evidence that older adults can benefit from psychological interventions to a degree comparable with younger adults. Recent evidence suggests that, unless irreversible brain damage has occurred, older people have learnt considerable flexibility in the use of their resources and while in some senses their defences may be more rigid, they also possess demonstrable capacity to use experience, varying frames of references in a creative and plastic way (Hildebrand, 1982). Hinze (1987) comments: "it is regrettable that psychoanalysts still seldom work with old patients - regrettable for many an old person who could be helped by psychoanalytical treatment and also regrettable for psychoanalysis itself, which thereby limits its horizons and takes insufficient account of the important phases of the life cycle". Moreover, Lewis and Butler (1974) mention that an interesting fringe benefit for therapists in working with older adults is the acquisition of a rich supply of information and models for their own eventual old age.

In summary it remains unclear whether Freud's early pessimism towards older adults has affected the views of subsequent psychologists and trainees. Scott & Bhutani (1999), in a survey of 127 third year and prospective first year trainees in the UK, suggest that some trainees expressed gross negative perceptions of the specialty and the client group. They further suggest that "many of the respondents' comments appeared to reflect a lack of knowledge about the breadth of the older adult psychologists' work" (p.13). Further investigation is needed to clarify the views of trainees regarding psychotherapeutic work in this area.

Countertransference Issues

The term countertransference is most often associated with and defined by the psychoanalytic school of therapy, although the term has been adopted in other schools of therapy (Knight, 1996). Greene (1986) describes countertransference as:

> *"the therapist's emotional reactions to the patient. This reaction is based on past relationships of the therapist rather than the 'real' attributes of the client" (p.80).*

Greene (1986) remarks that the literature has little to offer on the nature of countertransference mechanisms in psychotherapeutic work with older people. However it has been suggested that therapeutic relationships with older clients may give rise to conflicts and ambivalence in the psychotherapists themselves concerning personal ageing, parental figures, disease and death (Blum & Tallmer, 1977; Cath, 1972; Kastenbaum, 1978; Knight, 1996; Poggi & Berland, 1985). Woolfe & Biggs (1997) contend that "work with older clients confronts counsellors with a range of countertransferential issues, not least with fears about their own mortality which have hardly been addressed in the current research literature" (p.193).

Knight (1996) stresses that people working with older adults and especially therapists, who will be discussing these things on a more intimate level, are exposed to high levels of illness, dependency and death. He continues "the fact of chronic physical disability, the recognition of problems for which clients are not responsible and the sight of clients forced into dependency against their will all pose major threats to the younger adult worldview that effort is rewarded and we get what we deserve" (p.74). Some of these issues may inhibit work with older people, others may propel people to work with them (Poggi & Berland, 1985). Sobel (1980) suggested some therapists may have a "counterphobic" wish to master the fear of ageing which propels them to work with older adults.

Biggs (1989) suggests the lack of personal experience of old age allows disproportionate influence to be played by archetypal intrapsychic processes. It has been argued that the older adult is in a life-cycle phase that is outside the personal experience of most workers (Sprung, 1989). This is likely to be particularly true with trainees. Sprung (1989) argues that most worker's knowledge of older people comes from the lives of their parents, grandparents or other older relatives.

Fear of ageing

Lasher & Faulkender (1993) describe ageing anxiety as "the combined concern and anticipation of losses centred around the ageing process". Guttman (1982) suggests that ageing might arouse a "catastrophic view" and irrational phobias. However therapists' age could impact on anxiety about ageing: on one hand, older therapists could be expected to empathise more easily than younger with older clients; on the other, ageing therapists might experience higher gerontophobic feelings due to their own problems of ageing (Guttman, 1982; Ray et al., 1985; Settin, 1982).

Sprung (1989) argues that although all vulnerable populations stimulate uncomfortable feelings, these issues are especially pronounced when working with older people because of the universal nature of the ageing process. Providing services to older persons gives practitioners a glimpse of the difficulties of later life which may befall them in due course (Litwin, 1994).

Fear of death

> *"Of all things that move man, one of the principal ones is his terror of death."* Becker (1973)

Death anxiety has been proposed as a major obstacle to appropriate treatment and services for the elderly (Greene, 1986). Although death anxiety is not strictly a countertransference phenomenon (Greene, 1986), it has long been recognised that negative attitudes about death can play a role in the health professional's attitudes towards his/her clients (Berezin, 1977; Soyer, 1969). Hoelter (1979) defines death anxiety as "an emotional reaction involving subjective feelings of unpleasantness and concern based on contemplation or anticipation of any of the several facets related to death" (p.996). Philosophers speak of the

awareness of the "fragility of being" (Jaspers) or dread of "non-being" (Kiekegaard), of the "impossibility of further possibility" (Heidegger), or of "ontological anxiety" (Tillich).

The reluctance of professionals to interact with the dying has been widely documented (e.g. Feifel, 1959; Kubler-Ross, 1971; Nelson & Nelson, 1975). Working with the aged often brings the practitioner face to face with the decline of individual life and the health worker has to constantly face their own mortality (Greene, 1986). Research evidence suggests that professionals involved in working with older people and those close to death experience higher levels of death anxiety (Greene, 1983; Livingstone & Zimet, 1965; Weinstein, 1978).

However there are several methodological problems in the previous research. One weakness concerns the use of attitude measures of questionable reliability and validity (Collette-Pratt, 1976; Green, 1981; McTavish, 1971). The most widely used death anxiety scale is the Templer's Death Anxiety Scale (DAS: Templer, 1970), however this has been increasingly criticised on methodological grounds (Neimeyer, 1995). In particular it is susceptible to social desirability response bias (Dattel & Neimeyer, 1990) and has low internal consistency (Devins, 1979; Warren & Chopra, 1978). Many studies investigating death have failed to distinguish between fear of one's own death, one's fear of the death of another or one's fear of the effect of one's death on others (Yalom, 1980). DePaola et al. (1994) call for the use of more methodologically sound measures of death anxiety such as the Multidimensional Fear of Death Scale (Hoelter, 1979). This scale takes into account that death anxiety is not a unidimensional concept but can take on multidimensional, complex meanings (Hoelter, 1979; Nelson, 1975).

Definitional problems have plagued the field of death anxiety from the beginning (Neimeyer, 1995) and have impacted on attempts to measure it. However much people may profess to accept the reality of their death at a conscious level, it has been suggested that at an unconscious level they remain terrified of its occurrence (Becker, 1973; Firestone, 1994). Despite the fact that death is inevitable for all human beings individuals generally divert

themselves from thoughts of dying (Firestone, 1994). Furthermore, Menzies-Lyth (1988) argues that defences against the significance of death are not only personal but that there exist socially structured defense mechanisms. She describes society's tendency to split off problems, locating them in a small, split-off part of itself and thus partially disown them. However, the little research available raises more questions than it answers about the nature and extent of death anxiety denial (Neimeyer, 1994). It is often ignored and most authors of death anxiety scales "have assumed, at least implicitly, that death anxiety ... is a conscious experience" (p.188, Wass, Corr, Pacholski & Forfar, 1985).

Whether attitudes towards death correlate with career choice in terms of clinical specialisation remains to be determined (Lester, Getty & Kneisl, 1974; Neimeyer, 1994). Feifel, Hanson, Jones & Edwards (1967) hypothesised that one reason physicians chose their profession is their high fear of death. Health professionals might use their professions to help control personal concerns about death (Lester et al., 1974). However, any relationship between motivation to work with older adults and levels of death anxiety remain unclear.

Relationship between death and ageing anxiety and attitudes towards older people

As previously stated Butler & Lewis (1977) suggest that prejudice towards older adults is, in part, an attempt by younger generations to shield themselves from the anxieties of their own ageing and death. Research findings do suggest a tentative relationship between anxiety about ageing and death anxiety (Salter & Salter, 1976; Vickio & Cavanaugh, 1985), and attitudes to older adults (Salter & Salter, 1976). However it remains unclear how independent these constructs are from each other and from other scales. Lasher & Faulkender (1993) contend that ageing anxiety is separate from other measures of anxiety (e.g. state-trait anxiety and death anxiety) and from partially related structures such as attitudes toward ageing. Whereas in general the research indicates that respondents with exaggerated death anxiety (e.g. Conte, Weiner & Plutchik, 1982; Hintze, Templer, Cappelletty & Fredrick,

1994; Lonetto, Mercer, Fleming, Bunting & Clare, 1980), fear (Loo, 1984) and threat (Tobacyk & Eckstein, 1980) also obtain higher scores on traditional anxiety scales.

It has previously been suggested that negative attitudes towards older people may be mediated by death anxiety (DePaola et al., 1994; Eakes, 1985). However, confusion exists regarding the relationship between death anxiety and attitudes towards ageing. Although Vickio and Cavanaugh (1985) report that some researchers found death anxiety to be positively correlated with ageist attitudes, Salter and Salter (1976) found the reverse. Vickio & Cavanaugh (1985) further reported that increased death anxiety was correlated with greater personal anxiety towards ageing. The results of a study by DePaola et al., (1994) indicated that negative views of the elderly were associated with personal anxiety about ageing. Therefore the evidence suggests there is a lack of clarity about the relationship between death anxiety, ageing anxiety and attitudes to older people and further, whether they can be identified as separate constructs.

Fear of dependency

Some of the resistance to working with older people may stem from anxiety aroused in therapists by the dependency needs of their older clients (Yesavage & Karasu, 1982). Martindale (1989) comments that "with nearly all patients the dependency issue became a major anxiety for *therapists* within a few weeks of making contact with the patient. The therapists began to express dread at the length of the relationship that might develop - they began to feel trapped" (p.68). These issues can also arise at the end of sessions: "Therapists often hate to say goodbye to older people. They express fears that the older person will be lonely, will feel deserted, or is too frail to survive without support" (Knight, 1996, p.76). Stern, Smith & Frank (1953) called special attention to the anxiety aroused in the therapist by the unconscious identification with the helplessness of some older clients. Moreover therapists may have feelings that they should be doing more, whilst feeling that there is little

that they can do. They may fear that they will be overwhelmed by the presenting problem (Cohen, 1981).

The following sections will report on a number of studies which have examined factors that are important among both qualified psychologists and those in training on their choice of specialism. The impact of working experience with older adults on decisions to work in this specialty on qualification will be explored with particular attention to the core placement debate.

Choice of specialty

Recruitment and retention of clinical psychologists is a national problem which results from the well-documented shortage in qualified staff (MAS Report, 1988; MPAG Report, 1990; Kat, 1995). However as previously stated it is a particular problem in the older adult specialty. Thomas & Cook (1995) reported that in a survey of qualified clinical psychologists the older adult specialty was most frequently ranked the least attractive specialism of all four core specialisms. This finding was replicated by Scott (1997) in relation to third year trainees, of whom only six percent had chosen to work within the older adult specialty on qualification.

A number of studies have explored the factors which may influence choice of specialty amongst both clinical psychologists and psychologists in clinical training, a number of which will be reviewed. Lavender (1993) investigated the factors that appeared important in determining trainees' choice of first job. The twenty recently qualified clinical psychologists who responded to the survey indicated four major reasons for their choice of specialty: good support or organisation within the specialty, opportunities to use a variety of therapeutic approaches, jobs being available in that specialty and good experience as a trainee in that specialty. Lavender (1993) further reported that 60% (n=12) would have been able to predict specialty accurately at the time of their selection. The two most important factors

determining choice of job were the opportunity to work in the desired specialty (a finding replicated by Thomas and Cook, 1995, with a larger sample) and to receive good quality and regular supervision.

Scott & Bhutani (1999), in a survey of 127 third year and prospective first year trainees in the UK, reported that the main reasons trainees described for their choice of career path were: being attracted to variety of ages, therapy and presentations encountered (45%), availability of systemic work (27%), liking the client group (24%), the challenging nature of the specialty and the need to be creative (21%), finding the specialty interesting (18%) and experience prior to training (15%). Whilst Urquhart Law, McCarron & Wright (1999), who asked 20 trainees "What do trainees want in their first job after qualification?", reported the importance of good, regular supervision, spine point, specialty and geography, they further mentioned the increased importance of a cohesive psychology department, a good team of other professionals and good career opportunities.

In a study of 83 qualified clinical psychologists, Cuthbertson (1999) reported the overall atmosphere of organisation, management and the structure and head of service were rated as most important influences in terms of both recruitment and retention. These factors came above grading and other professional issues, such as supervision and continuing professional development (CPD).

In terms of increasing recruitment to the older adult specialty, the trainees in Scott & Bhutani's (1999) survey suggest training courses might like to aim to secure "better quality" training (43%), improve teaching (31%), raise the profile of research (8%) and prepare trainees for the systemic way of working. They further stated that "professionals in the specialty might aim to stress the breadth of their role within the PR and selling campaign suggested by 38 percent of the respondents" (p.13). Howells (1992) comments that working with elderly people may mean working as the only clinical psychologist, which is also likely to deter potential recruits.

Experiences of working with older people prior to and during training

The 1980s saw the development of a separate and specific component of teaching related to older adults and strenuous efforts to ensure that teaching extended to this age group (Britton & Woods, 1996). Pressures over many years also resulted in the establishment of compulsory placements with older people in the early 1990s, or as an alternative, a clear and specific component of a wide range of practical work with this client group (Britton & Woods, 1996). All UK training courses now have a specific component on work with older people.

However although the profession has been seeking to increase the number of training places, the result of this expansion has meant that it has been increasingly difficult to find supervisors for core placements (Gray, 1997). This has been described as "one of the greatest sources of anguish for course organisers" (p.41). Ending core placements has evolved as one of the possible solutions to the difficulty of finding sufficient numbers of training placements in the core areas (Ashcroft, Callanan, Adams, Roth, Gray & Lavender, 1998; Ashcroft & Callanan, 1997). As a result, the recent rewriting of the Criteria for Accreditation for Clinical Psychology Courses has moved its emphasis from four core placements (Adult, Child, People with learning disability and Older people) to core experience (Ashcroft & Callanan, 1997). Ashcroft & Callanan (1997) suggest that "a trainee may gain experience with Older Adult work via a mix of neuropsychology or health psychology or adult placement experience" (p.41). However, there is a concern that any move to end core placements may threaten recruitment to specialties such as services for older people (Ashcroft et al., 1998). Ashcroft et al. (1998) continue that "in considering change it will be important to ensure that training and recruitment to the core areas relating to work with children, older adults and people with learning disabilities is not jeopardised" (p. 51).

This has raised a dilemma for the profession as a whole and more specifically for the older adult specialty. A 1995 survey of training courses suggested that for 21 of the 23

courses, difficulty in finding older adult placements would limit expansion; in comparison, 13 courses cite learning disabilities and child/adolescent placements as being in short supply (Turpin, 1995). A further complication is pointed to by Scott (1997) when she comments that "improving the quality of older adult placements can only be achieved by significantly increasing the number of available supervisors, and to do that, the specialty needs to tempt qualifying trainees to work within it" (p.15).

Previous research that has examined the question as to whether pre and during training experience of working with older adults impacts on trainees' decisions to work in this specialty will be explored. Bhutani (1995/1996) argued that trainees have a tendency to stick to the choice of specialty they decided on pre-training. Further research suggests that for approximately 50 percent of both trainees and qualified clinical psychologist pre-training experience has an important influence on choice of specialism (Scott, 1997; Thomas & Cook, 1995). However Thomas & Cook (1995) found pre-training experience had less of an influence for those currently working with older adults. In a survey of 42 trainees, Howley (1999) found that experience during training deters people from working with older adults once qualified, whereas experience previous to training was positively correlated with desire to work with older people.

The pressure to expand training is great and in this context, compulsory older adult placements may be vulnerable (Britton & Woods, 1996). However, Gilleard et al. (1995) argue that "whilst solving the logjam problem of too many trainees and not enough placements, such proposals will do little to increase the number of psychologists interested and experienced in working with an older adult clients group" (p.14). Britton & Woods (1996) argue that "although working with older people is often a less popular choice initially there is nothing as effective as a good placement experience in persuading a trainee that this area is worth a second look in terms of career choices" (p.11). Similarly, Bhutani (1995/1996) suggested that negative attitudes to working in this specialty are related to a lack of experience of working with older people. However, Scott's (1997) survey found that even

though 75 percent of the third years said they had enjoyed their older adult placement and 57 percent commented that they would consider a career in this specialty only 6 percent (3 trainees) had taken a post in this area.

Summary

In summary, some previous studies have found the older adult specialty less popular with a range of mental health professionals, including clinical psychologists and psychologists in training. This is a growing cause for concern given the increasing number of older people, a significant percentage of whom will have mental health problems. The reasons why working with this age group seems unattractive remain unclear. Ageism has been proposed as having some influence, psychologists have been thought to possess negative views about older people which discourage them from working in this area, however this finding has been contested (Knight, 1996). Furthermore others have suggested that assumptions of ageist attitudes among professionals have been overestimated (Gatz & Pearson, 1988) and that mental health professionals are generally positive about working with older people (O'Leary, 1995). Both death anxiety and ageing anxiety have been suggested to be heightened through work with older clients, however it remains unclear how they impact on psychologists' motivations to work with this age group. Furthermore these constructs themselves may be interrelated which will impact on their measurement.

There is also a debate in the literature as to the value therapists place on working with older adults and the strength of their belief in the possibility of positive outcomes. Psychology trainees' attitudes to the potential for psychotherapeutic work with this group and their ideas as to what might hamper such therapeutic endeavours are unknown.

Rationale for the current study

Establishing attitudes of clinical psychology trainees to working within the older adult specialty has been identified as an important issue to explore, given the growing number of people aged 65 and over and the previous difficulties with recruitment. Determining the factors which may predict interest in this specialty among trainees is likely to be helpful when considering improving recruitment. The focus on trainees rather than qualified psychologists will highlight current training issues and facilitate an examination of current feelings among trainees about working in this specialty. Many of the previous studies have focused on a small subset of trainees; this research planned to allow the voices of the majority to be registered. Furthermore this study hoped to encourage a discourse concerning what influence working with older adults during training might have on future preference to work with this age group.

Aims

1. To explore how interested current clinical psychology trainees are to work with older people in relation to other specialty areas and to attempt to discover which factors might predict interest to work in this specialism.

2. To investigate clinical psychology trainees'

- attitudes towards older people
- attitudes to psychotherapy with older people
- anxieties around death and dying
- anxieties around personal ageing and
- experience of working with older people

3. To explore issues around recruitment to work within psychology services for older people. It is hoped that this study will lead to recommendations which will aid recruitment.

4. To explore the relationship between the measures used. This research is dependent on questionnaires, however questionnaires have their limitations - "no tests are without an error

component" (Powell, 1989). For this reason it was thought to be important to check their methodological soundness and to establish the strength of associations between the scales, which is in part a function of the error associated with the measures.

5. To explore the issue of core experiences in training and whether experience of working with older people during clinical training influences decisions to work with this group on qualification.

Research questions

- How popular is the older adult specialty in relation to other specialties among current trainees?

- Will motivations to work with older people be mediated by levels of death and ageing anxiety, attitudes towards older people, age, experience of working with older people during and prior to clinical training and attitude to working with older people prior to training? Which of these factors seem to predict most strongly trainees' interest in working with older people?

- How reliable and valid are the scales that have been chosen to measure the above variables? How much overlap is there between the scales and do the questions contain similar questions? Will death anxiety, social value of the elderly and ageing anxiety be highly correlated?

- What are trainees' attitudes to psychotherapy with older adults? What are thought to be the most emotionally rewarding and challenging aspects of this work?

- Why might it be difficult to recruit and how might recruitment to this specialty be improved?

Method

Design

This study was a cross-sectional postal survey, involving psychologists in clinical psychology training from three cohorts (1996-1998 intakes) and from 25 of the Clinical Psychology Training courses in the UK. A postal survey was used in order to access a larger number of potential respondents and to assist with issues of anonymity and confidentiality.

Participants

Of the 895 surveys distributed, 371 were returned (41% response rate). Of those respondents indicating their gender, 16% were male (N=59) and 83% were female (N=307). The mean age was 28.3 years (SD=4.00), ranging from 21 to 47 years. One hundred and thirty-three respondents were first years (35.8%), 108 second years (29.1%) and 107 third years (28.8%), while 6.2% (N=23) did not indicate their year of training.

Forty-eight percent (n=178) of the respondents had some experience of working with older adults prior to training. Of this subset, 42% (n=81) had worked with older adults as assistant psychologists, 37% (n=72) as care assistants, 9% (n=17) as qualified nurses, 8% (n=15) in research and 5% (n=10) had been volunteers with this age group. Average length of time working with older people prior to training was 20 months (SD=20.49) with a range from one month to ten years.

Measures

A questionnaire was designed by the author based on the literature reviewed (Appendix One) It included a number of published measures, chosen because they were thought to be the most valid and reliable. The completed questionnaire included:

1. Demographic information: age, gender, ethnic origin, year of training and experience of working with older people both prior and during training. Participants were additionally asked which client groups they were most interested to work with on qualification, for their opinions about working with older adults and for their ideas about recruiting to the older adult specialty.

2. ***The Psychotherapy with the Elderly Questionnaire*** (PEQ: Smotkin et al., 1992) and further questions devised by the researcher were used to determine trainees' attitudes towards psychotherapy with older people. The PEQ includes a list of 25 phenomena stereotypically associated with old age. These phenomena were selected by Smotkin et al., (1992) from questionnaires of attitudes towards older people (e.g. Palmore, 1977; Rosencranz & McNevin, 1969; Tuckman & Lorge, 1953). This scale measured the degree to which trainees supported previous stereotypical ideas about working psychotherapeutically with older people.

3. ***The Social Value of the Elderly Scale*** from the Aging Opinion Survey (AOS: Kafer, Rakowski, Lachman & Hickey, 1980) was used to assess attitudes towards older people. This 15 item scale taps several areas, generally indicating interpersonal relations and the place of older persons in the community (e.g. residential segregation, social responsibility, public policy and knowledge). Lower scores are indicative of more perceived social value. This scale was chosen as it provides a measure of positive and negative attitudes to older adults as a generalised-other group.

4. ***The Anxiety About Aging Scale*** (AAS: Lasher & Faulkender, 1993) has twenty items with four subscales and five items in each subscale:

- fear of old people, which assesses external contact with others. The authors suggest it taps anxiety about ageing in an individual who may be more defensive about ageing anxiety.

- psychological concerns, which focuses on important psychological tasks that one must face in order to facilitate a positive adjustment in old age, and all are directly related to Erikson's proposed psychological conflict of 'integrity versus despair' (Erikson, 1982; Erikson, Erikson & Kivnick, 1986).
- physical appearance, which contains items relating to anxiety about how one's physical looks change with age.
- fear of loss, which relates to something being taken away or lost in old age. As such it has an external focus.

Lasher & Faulkender (1993) reported Cronbach's reliability of the total twenty item AAS was 0.82. Alpha coefficients for the four factors ranged from 0.69 to 0.78 (mean score of 0.71). They further reported there is still a question as to whether the construct of "ageing anxiety" measured by the AAS will stand apart from other measures of anxiety, e.g. death anxiety (Lasher & Faulkender, 1993). This scale was used because it assesses the multidimensionality of ageing anxiety.

5. ***The Multidimensional Fear of Death Scale*** (MFODS: Hoelter, 1979) was used as the best available measure of death anxiety (DePaola, Neimeyer & Ross, 1994). The MFODS is a forty two item scale that consists of eight fear of death dimensions:

- fear of the dying process, dealing with the specific act of dying rather than with any related consequences accompanying death;
- fear of the dead, pertaining to people or animals that have died;
- fear of being destroyed, which deals with human destruction of one's body immediately following death;
- fear for significant others, relating to fear of significant others dying as well as fear associated with the effects one's death may have on significant others.
- fear of the unknown, which deals with the ambiguity of death and the ultimate question of existence;

- fear of conscious death, which deals with living horrors associated with the immediate processes subsequent to death whereby the pronouncement of death is not accepted to be the final termination of consciousness;
- fear for body after death which is associated with concerns for bodily qualities after death and
- fear of premature death which is based on the temporal element of life and concerns the failure to achieve goals and experiences before death.

Hoelter (1979) found internal consistency coefficients yielding a mean of 0.75 for all eight factors and a further study by Walkey (1982) also found a mean alpha coefficient of 0.75. Walkey's study (1982) strongly supports Hoelter's claim of eight independent subscales with high reliabilities. Walkey (1982) found that only factor 8 (fear of premature death) seriously departed from the expected structure, and even it conformed to the expected structure once a single problematic item was excluded. However, Long (1985-6) found "little support" for Hoelter's (1979) model when surveying a group of male Saudis. He concluded that many of the specific fears associated with death in a Western Christian culture (e.g. fear of being destroyed and fears of the unknown) may not be applicable to members of the Islamic community.

Neimeyer & Moore (1994) found the test-retest reliability for the factors ranged from 0.61 (Factor 4, fear for significant others) to 0.81, with a mean of 0.74. They suggested that the subscales of the MFODS appear to tap relatively enduring aspects of individuals' fears of death.

Hoelter (1979) suggest that validation of this scale is "obviously problematic because of the large number of suggested fear of death dimensions" (p.997). Neimeyer & Moore (1994) suggest that the construct validity of the MFODS is demonstrated by its ability to discriminate relevant groups and converge with alternative measures of death concern. DePaola, Neimeyer, Lupfer & Fielder (1992) provided preliminary support for the validity of

the MFODS in terms of its convergence with an established measure, the Threat Index (Neimeyer & Moore, 1989). Furthermore, Holcomb, Neimeyer & Moore (1993) found the results of the MFODS related to themes analysed in free response narratives, providing evidence that respondents who score high on the MFODS have very different death attitudes from those who score low on the measure.

Procedure

Permission was sought from course directors to approach their trainees (see Appendix Two). When permission was obtained, questionnaire packs were distributed in line with directives from the course directors/administrators. The packs contained the questionnaire, a covering letter (Appendix Three) and a self-debriefing form (Appendix Four). Where consent was obtained the packs were personalised - a technique suggested to increase response rates (Maheux, Legault & Lambert, 1989). Eight hundred and ninety-five packs were distributed (58% were personalised) to twenty five of the twenty six training courses. Trainees were provided with a pre-paid envelope.

The trainees were also sent a form to complete if they chose not to participate (Appendix Five) and a form to request a summary copy of the results (Appendix Six). A summary of the reasons for non-participation can be seen in Appendix Seven.

Pilot

A pilot of the questionnaire was completed by 20 trainees at the South Thames (Salomons) Training Scheme to determine any ambiguous questions; trainees were asked for their comments regarding the questionnaire (see Appendix Eight). The trainees were asked to repeat the quantitative scales after three weeks as a measure of test-retest reliability. After piloting, the order of the questionnaires was changed as well as the wording for some of the questions (Appendix Nine).

Ethical Issues

This research was scrutinised by the Ethical Committee at the South East Thames (Salomons) Clinical Psychology Training Scheme and ethical approval granted (Appendix Ten).

Confidentiality

The confidentiality of trainees' responses was assured and stamped addressed envelopes were used in an attempt to preserve anonymity. In the presentation of results every effort was made to protect participants' anonymity. Additionally trainees from the same course (South Thames - Salomons) as the researcher were not used as part of the main study, as ethically this was considered inappropriate.

Consent

Since participation was voluntary, consent was assumed by virtue of returned forms. The aims and objectives of the research and the planned dissemination of the results were made explicit in the covering letter so that trainees could make an informed decision about whether they wished to participate. Additionally trainees were advised to contact the researcher if they had any further questions about the nature of the research. The participants were informed that the survey was anonymous and the data collected from the research would be shredded after analysis.

Debriefing

It was recognised that some personal issues may arise whilst completing the questionnaires, as such the following support systems were set up:

1. Participants were encouraged *not* to participate if they felt that answering the questionnaires would be unreasonably stressful, e.g. if they had recently been bereaved.

2. A debriefing form was sent with the survey. The participants were encouraged to complete this and given the option to send the completed form to the researcher.

3. The trainees were advised that they could contact a named member of the course staff at Salomons Centre for debriefing if necessary.

4. Finally they were informed that they could contact the researcher directly to discuss any concerns.

Re-submission to ethical committee

The foremost ethical concern was that trainees should not feel obliged to take part in the research if it would be distressing. After approximately 500 of the surveys had been sent out four replies suggested trainees had felt obliged to fill in the questionnaire, although they would have preferred not to because of personal issues or pressure of work. At this point the researcher returned to the ethical committee and it was agreed that the paragraph concerning participation was highlighted (Appendix three). During the study no-one took the opportunity to contact the member of course staff for debriefing.

Data management

Descriptive analyses were completed for all the variables. A multiple regression was computed to determine which independent variables predicted the variance in the dependent variable: interest in working with older people. Correlations were used to determine the relationship between scores on the anxiety about ageing scale, the death anxiety scale and the social value of the elderly scale. Cronbach's alpha was computed for these scales to assess internal consistency.

Qualitative data analysis

Content analysis was used to analyse the open questions. This method is commonly used to analyse written text (Krippendorff, 1980) and allows for the "objective, systematic and quantitative description of the manifest content of communication" (Berelson, 1952, p.18). The answers to sixty of each question were read and these responses used to devise a coding frame. Initially around 12 categories were produced as suggested by Oppenheim (1992). These categories were then collapsed until it was decided that further reduction would mean losing important data. When the categories had been established they were clearly described (Appendix Eleven) and examples included. Each interview was then coded separately and numbers of occurrences of each category were calculated for each of the relevant questions (Oppenheim, 1992).

In an attempt to address the issue of reliability, a research psychologist independently coded 20 surveys using the frames and percentage agreement was calculated. Initially to aid definitional clarity difficulties were discussed (Miles and Huberman, 1994).

Inter-rater reliability

Inter-rater reliability was calculated for the six relevant questions. Kappa coefficients ranged from .85 to .96 with a mean score of .91. Robson (1993) reports that kappa in the range 0.4 to 0.6 is considered fair between 0.6 and 0.75 is good and above 0.75 is excellent.

Results

Data management

The data were examined to determine whether parametric analyses could be used. All the variables approximated a normal distribution apart from: age, interest to work with older people prior to training, AAS: fear of old people, AAS: psychological concerns, MFODS: fear of conscious death, MFODS: fear of the dying process and MFODS: fear for significant others (Appendix Twelve). These variables were transformed, using logarithmic transformations for positively skewed distributions and squared or cubed for negatively skewed distributions (Clark-Carter, 1997). Data transformations resulted in a reduction of skewness for all but one of the variables: MFODS: fear for the body after death (Appendix Twelve). It has been argued that many statistical procedures for parametric data are robust to minor violations of the assumptions of parametric data; in particular the normality assumption can be violated with minor effects (Howell, 1992). Therefore, following statistical advice parametric tests were used for the analyses. However for one factor (MFODS: fear for the body after death), the assumptions for parametric statistics were violated beyond reasonable limits and this factor was not used in the analyses.

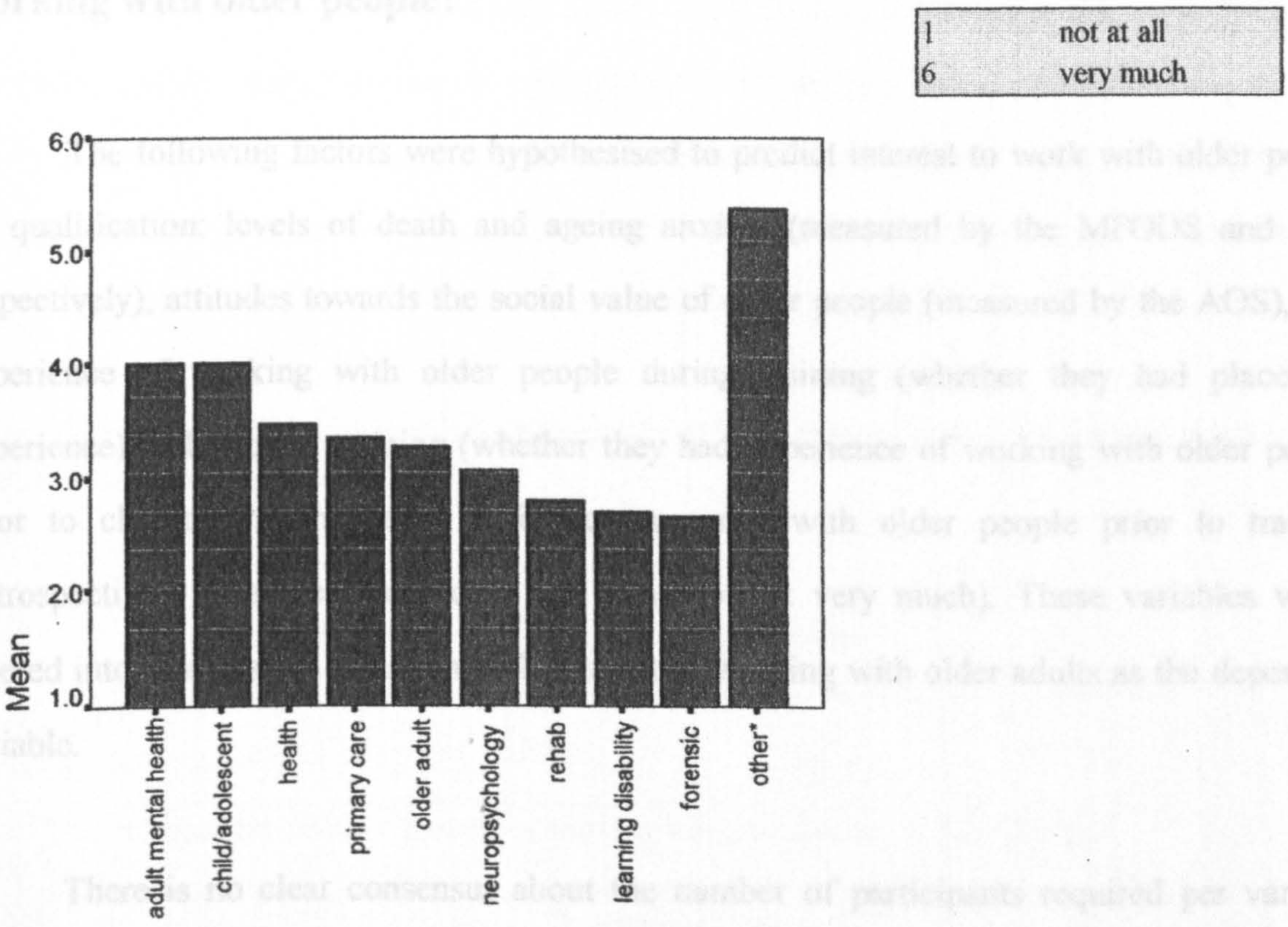
Table One: Summary of analysis for each research question

Research Question	Method of Analysis
How popular is the older adult specialty in relation to other specialties?	Mean scores
Are specific factors involved in mediating decisions to work with older people? Which of these factors seem to predict most strongly trainees' interest in working with older people?	Multiple regression (Stepwise) Wilcoxon signed rank test
How reliable and valid are these scales with this group? Will death anxiety, social value of the elderly and ageing anxiety be highly correlated?	Pearson's correlations and Cronbach's alpha
What are trainees' attitudes to psychotherapy with older adults? What are the most emotionally rewarding and challenging aspects of working with older people?	Frequency counts and content analysis
Why might it be difficult to recruit and how might recruitment to this specialty be improved?	Content analysis

How popular is the older adult specialty in relation to other specialties?

Trainees were asked to rate their interest in working in the different specialties once qualified on a scale of one (not at all) to six (very much), the mean results can be seen in Figure One.

Figure 1: Trainees' current preference for specialty after qualification (mean score, N=358)



* Nine percent of trainees (N=33) indicated they would like to work in other services including addiction, paediatrics, PTSD, sexual health, research and community psychology.

The results suggest the most popular specialties among the trainees surveyed were adult mental health (mean score of 4.02, SD=1.63) and child and adolescent services (mean score of 4.02, SD=1.40). The older adults specialty was the fifth most popular. Fifty six percent (N=201) of the trainees rated their interest in working with older adults on qualification between one to three, whilst 43.9 percent (N=157) rated it between four and six (see Figure 3), with a mean of 3.28 (SD=1.46).

Respondents were given the option of rating their interest in any area not listed. The nine percent (N=33) who indicated an interest in this "other" category rated it highly, 91% (N=30) as either five or six.

Which factors are involved in mediating decisions to work with older people? Which factors seem to predict most strongly trainees' interest in working with older people?

The following factors were hypothesised to predict interest to work with older people on qualification: levels of death and ageing anxiety (measured by the MFODS and AAS respectively), attitudes towards the social value of older people (measured by the AOS), age, experience of working with older people during training (whether they had placement experience) and prior to training (whether they had experience of working with older people prior to clinical training) and preference to work with older people prior to training (retrospectively measured from one: not at all to six: very much). These variables where entered into a regression equation with interest in working with older adults as the dependent variable.

There is no clear consensus about the number of participants required per variable (Howell, 1992) for multiple regression analysis. However Clark-Carter (1997) suggests "if you are simply interested in the proportion of variance in the DV [*dependent variable*] which is accounted for by the IVs [*independent variables*] then use the rule of at least 50 participants more than the number of IVs" (p.354). Furthermore for twelve variables with a medium effect size (R squared = 0.13), approximately 130 participants would be needed to achieve a power of 0.8 (Clark-Carter, 1997). Given the number of respondents and the power and effect sizes recommended by Cohen (1988) a limit of fifteen independent variables was used in the regression equations.

The stepwise method was used to develop the regression equations. This allowed for the ability to examine the effect of each of the variables, taking into account any interaction

between them. Furthermore as there were no clear expectations about which of the factors might have the largest effect, the stepwise method of entering the variables was preferred for this more exploratory approach. The variables were entered into the equation at the significance level of $p<.05$ and selected out at significance level $p<.1$. Analysis of the residuals revealed one outlier which was excluded from the analysis. Prior to running the multiple regression analyses, the relevant variables were entered into a correlation matrix to determine the existence of multicollinerarity (Appendix Thirteen). As none of the variables were correlated at $r=.8$ or over they could be considered independent and could all justifiably be included in the regression analyses. The results of the multiple regression can be seen in tables two and three.

Tables Two & Three: Stepwise multiple regression to identify factors predicting interest in working with older adults on qualification (N=349)

R squared	Adjusted R squared	F value	df
0.331	0.326	57.17 (p<.001)	349

Dependent variable: interest in working with older adults on qualification

Predictor variables	Standardised Beta Coefficients	Probability	95% confidence levels for B
Interest in working with older people prior to clinical training	0.468	p<.001	.95 to 1.41
AAS: fear of older people	0.212	p<.001	.03 to .08
Older adult placement experience	0.158	p<.001	.18 to .70

Three independent variables were found to be significant predictors of trainees' interest in working within the older adult specialty after training. These were (1) their interest in working with older people prior to training, (2) their score on the fear of old people factor of the AAS and (3) whether they had any experience of working with older people during

training. These independent variables accounted for 33% of the variance in the dependent variable: trainees' interest in working within the older adult specialty after training.

This result was confirmed by repeating the multiple regression using the forward method of entry which gave very similar results (i.e. an Adjusted R squared score of 0.329). The scatterplot of residuals against predicted values showed no trends, whilst the P-P plot (observed standardised residuals plotted against the expected normal distribution) showed a linear relationship.

It can be seen from the results that the main predictor of trainees interest to work with older adults was their interest in this area prior to training (standardised beta coefficient=0.468). Therefore a further regression was completed to assess which of the variables might predict trainees' interest in working with older people prior to training, see tables four and five:

Tables Four & Five: Stepwise multiple regression to identify factors predicting interest in working with older adults prior to training (N=349)

R squared	Adjusted R squared	F value	df
0.233	0.229	54.818 (p<.001)	351

Dependent variable: interest in working with older adults prior to training

Predictor variables	Standardised Beta Coefficients	95% confidence levels for B	Probability
Experience of work with older adult before clinical training	0.383	.35 to .57	p<.001
AAS: fear of older people	0.239	.02 to .04	p<.001

These results showed two independent variables, experience of working with older adults prior to training and scores on the AAS: fear of the old, accounted for 23% of the

variance in the dependent variable: interest in working with older people prior to training. These results were supported by repeating the multiple regression with the forward method of entry, when the Adjusted R squared score was 0.224. The scatterplot of residuals against predicted values showed no trends and analysis of the residuals revealed no outliers. The P-P plot showed a linear relationship.

The trainees were asked what factors influenced their decisions to work with a given client group. The answers to this question were analysed using a content analysis (as discussed in the method section) and the results can be seen below in table six. The most frequently mentioned categories were previous experience/previous work (45%, N=168), previous placement or training experience (37%, N=168), personal interest (26%, N=95) and enjoyment/satisfaction (19%, N=69).

Table Six: Factors influencing choice of specialty among trainees (Total N=371)

Categories	Percentage	Rank
Previous experience/previous work	45% (N=168)	1
Training/placement experience	37% (N=138)	2
Personal preference/own interest/personal qualities *[Personal choice, outside interest]*	26% (N=95)	3
Enjoyment/satisfaction/stimulating/challenging	19% (N=69)	4
Previous assistant psychologist experience	13% (N=50)	5
Lack of experience and lack of confidence in the area/too early to decide	11% (N=45)	6
Diversity, variety and flexibility of post	8% (N=29)	7
Interest/preference for a particular theoretical model more associated with client group	8% (N=30)	8
Academic issues/research	7% (N=27)	9.5
Ability to impact/speed of change/difficulty	7% (N=26)	9.5
Teaching and reading	6% (N=22)	12.5
Work conditions	6% (N=22)	12.5
Enthusiasm for client group/relating/not relating to client group	6% (N=22)	12.5
Confidence/understanding/knowledge	6% (N=22)	12.5
Opportunities for employment	4% (N=13)	15
Miscellaneous	3% (N=12)	--
Missing	5% (N=19)	--

As previously described, the trainees retrospectively rated their interest in working with older adults prior to training on a scale from one (not at all) to six (very much). The results can be seen in figure two below. Figure three represents trainees interest in working with older people on qualification (the mean of which can be seen in table one).

Figure 2: Interest in working with older adults prior to training (N=369)

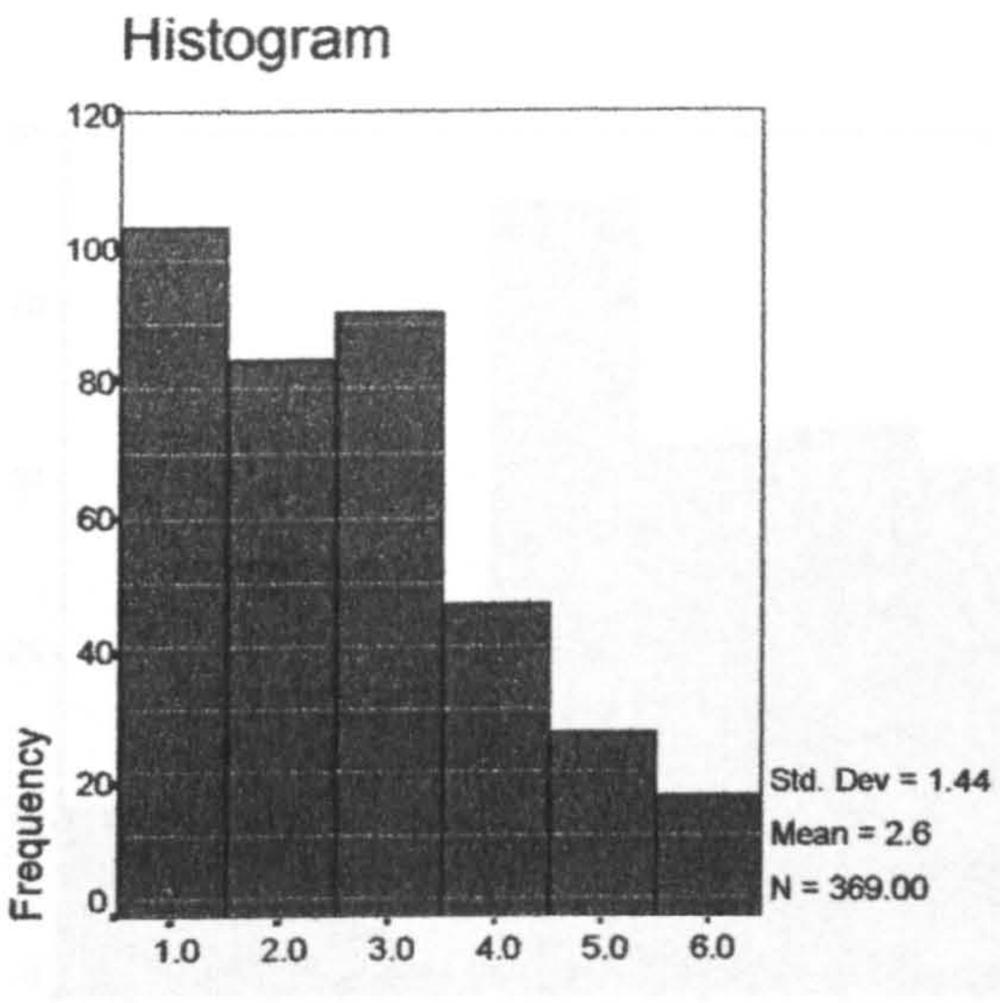
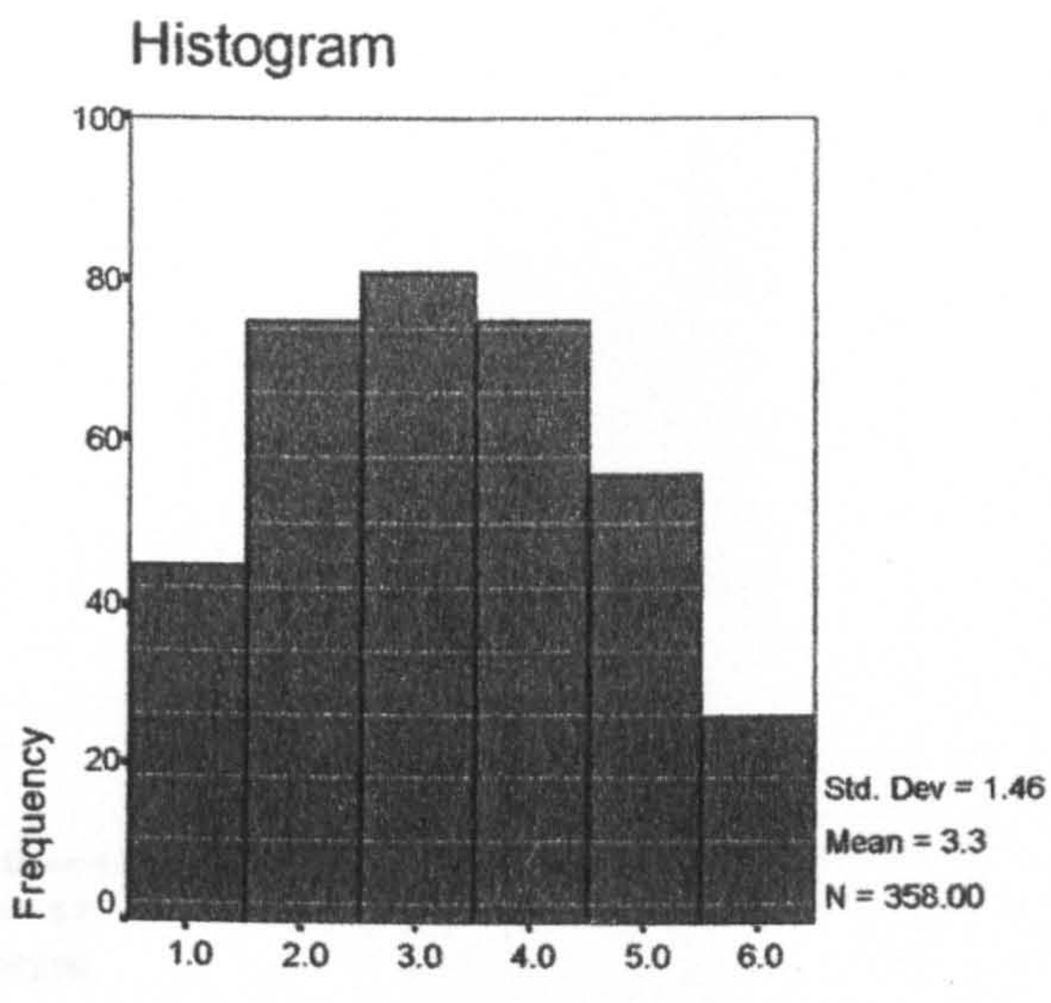


Figure 3: Current interest in working with older adults on qualification (N=358)

1	not at all
6	very much

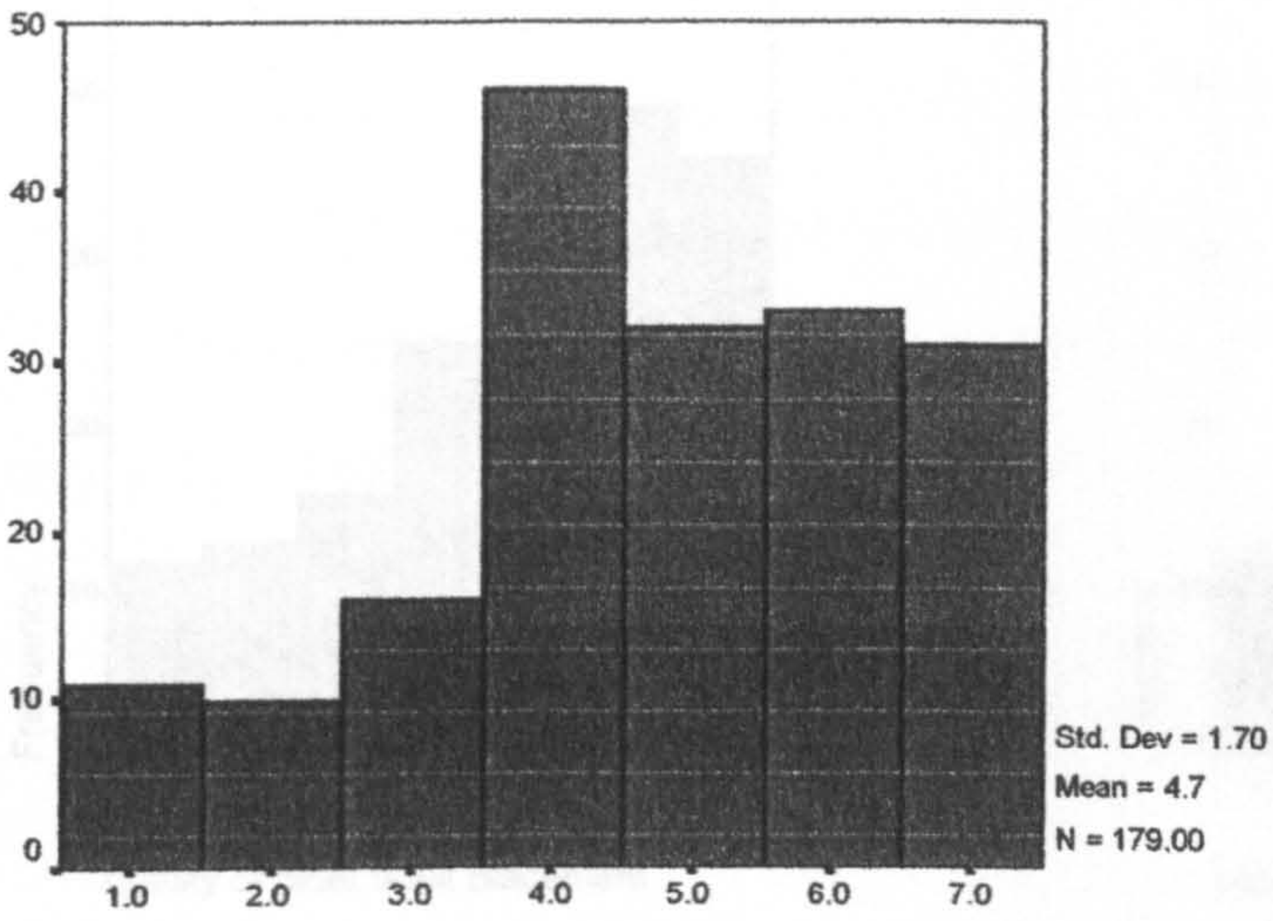


These results suggest the trainees surveyed were more likely to state during rather than prior to training that they would like to work within the older adult specialty once qualified. Wilcoxon Signed Rank test revealed that the scores were significantly different ($Z=-9.364$, $p<.001$), therefore trainees were significantly more likely to state a preference to work with older people during training than pre-training.

The trainees were asked about the influence of their experience of working with older adults during training on their decision to work within the older adult speciality on qualification. This was scored on a scale of one (less likely to work in older adult specialty following placement experience) to seven (more likely). This question was only answered by the 179 trainees who had some experience of working with older adults during their training. The results are shown in figure 4. The majority of the trainees (51.5%, N=191) had not had their older adult placement, 39.1% (N=145) had had a placement or were currently on a placement with a supervisor working specifically in services for older people, whilst 9.4% (N=35) had gained their "core experience" of working with older adults from other specialties e.g. rehab, AMH, ranging from one to four other placements.

Figure 4: Influence of placement on decisions to work in the older adult specialty (N=179)

1	less likely to work in older adult specialty
7	more likely to work in older adult specialty



This seems to suggest that experience of working with older adults during training makes trainees rate themselves as more likely to work with older people on qualification (mean score = 4.7, SD=1.70). Fifty three percent (N=95) rated themselves between five and seven and 21% (N=38) rated themselves between one and three. However the mode score of four suggests that many trainees (25.7%, N=46) were neither more or less likely to want to work with older adults having had their placement experience.

Those trainees who had some experience of working with older people during training were asked to rate the quality of their placement and their supervision (see figures 5 and 6).

Figure 5: Quality of older adult placement (N=175)

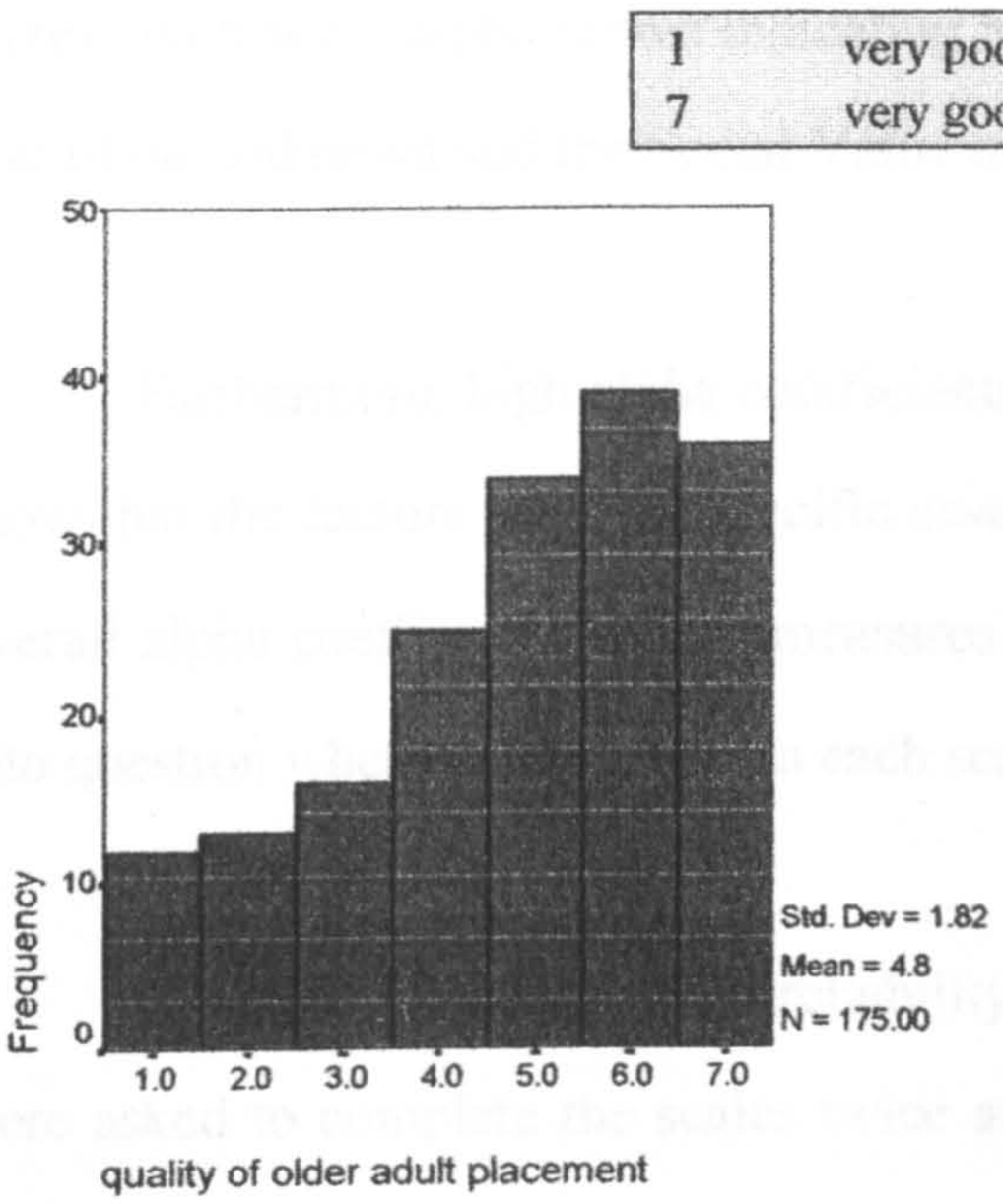
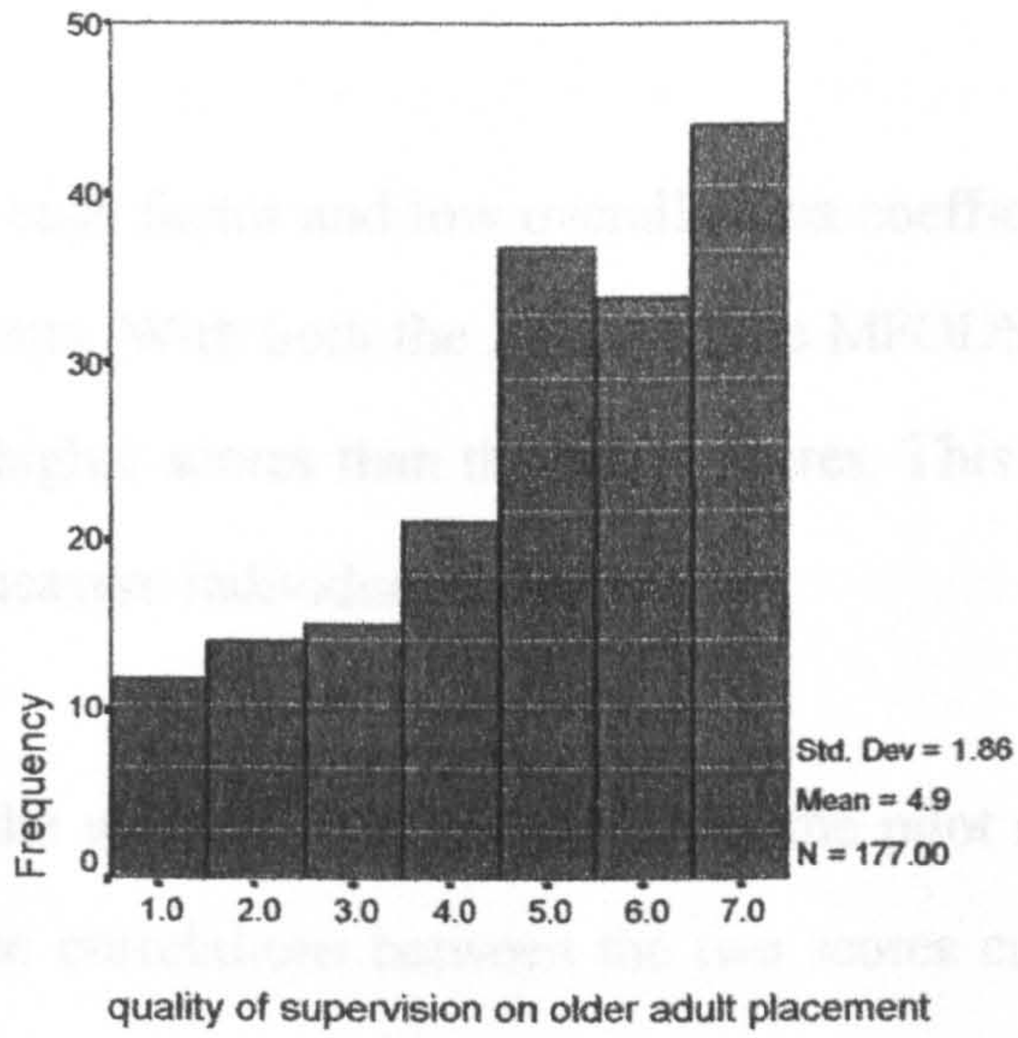


Figure 6: Quality of supervision during older adult placement (N=177)



In general the trainees tended to rate their older adult placement and supervision highly, 76% (N=134) rating the quality between four and seven for both; however 12 respondents (7%) reported both as very poor.

How reliable and valid are these scales with this group? Will death anxiety, social value of the elderly and ageing anxiety be highly correlated?

To establish the internal reliability of the questionnaires Cronbach's alpha, as a measure of the homogeneity of test items, was computed for each factor and for each measure itself. Cronbach's alpha coefficient for the Social Value of the Elderly Scale was 0.57; for the Anxiety about Aging Scale the overall Cronbach alpha was 0.83 and the scores for the individual factors range from 0.61 (fear of loss) to 0.82 (fear of old people), with a mean alpha score for all four factors of 0.73. The overall Cronbach alpha score for the Multidimensional Fear of Death Scale was 0.89, excluding the fear of the unknown score (0.48), alpha scores for the factors ranged from 0.69 (fear for significant others) to 0.82 (fear of the dying process), with a mean of 0.75. Rust and Golombok (1989) suggest using a cut-off score of 0.7, with

results above this suggesting high internal consistency. These results therefore show a mixed picture with some alpha scores indicating high internal consistency whilst others e.g. MFODS: fear of the unknown and the Social Value of the Elderly (AOS) do not.

Furthermore, high alpha coefficients for each factor and low overall alpha coefficients show that the factors measure specific components. With both the AAS and the MFODS, the overall alpha coefficients for the measures are higher scores than the factor scores. This calls into question whether the factors in each scale measure individual components.

To explore the test-retest reliability of the measures the trainees from the pilot study were asked to complete the scales twice and the correlations between the two scores can be seen in table seven. Kline (1993) sees r=.8 as a minimum for examinations of test-retest reliability. These results suggest that many of the measures have poor reliability over time, with only AAS: fear of older people and AAS: psychological concerns scoring over 0.7. However the sample size is small.

Table Seven: Test re-test reliability for pilot sample

Measures	Spearman's rho	N
The Social Value of the Elderly Scale	0.134	19
AAS: fear of old people	0.709**	17
AAS: psychological concerns	0.737**	19
AAS: physical appearance	0.358	19
AAS: fear of loss	0.435	19
MFODS: fear of the dying process	0.354	18
MFODS: fear of the dead	0.622**	18
MFODS: fear of being destroyed	0.651**	19
MFODS: fear for significant others	0.588**	19
MFODS: fear of the unknown	0.681**	19
MFODS: fear of conscious death	0.562*	18
MFODS: fear for body after death	0.573*	19
MFODS: fear of premature death	0.586**	19

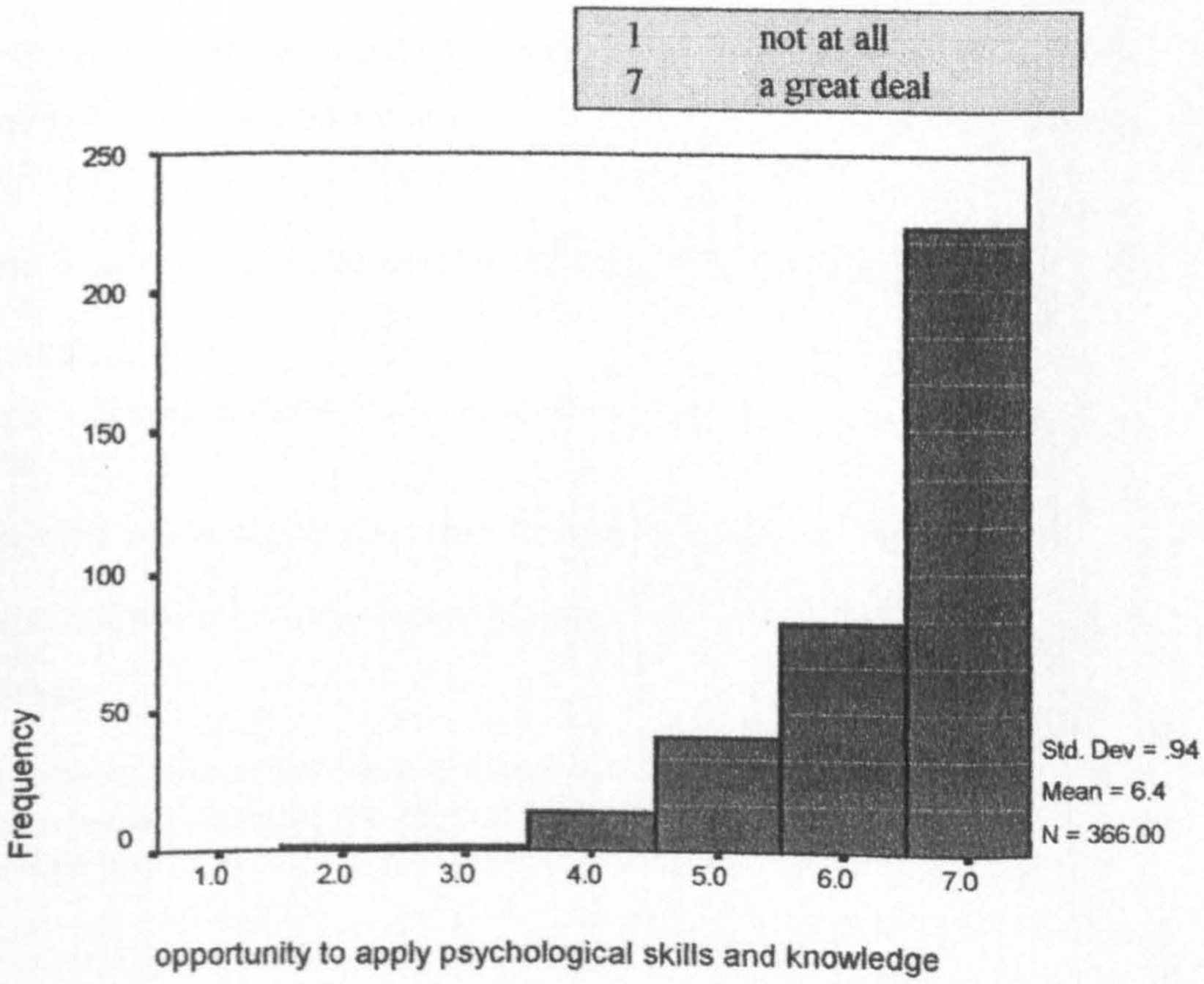
** correlation is significant at the 0.05 level (2-tailed)*
*** correlation is significant at the .01 level (2-tailed)*

To establish whether the scales contained similar statements a research psychologist was given each statement and asked to decide to which scale it belonged. She correctly identified all of the statements from the MFODS, however she placed the statements assessing fear of old people from the AAS into the AOS. Apart from this she correctly distinguished the statements from the AAS and the AOS. Pearson's correlations were used to determine whether the factors in one scale measured areas independent to the factors from the other two scales (Appendix Thirteen). Correlations ranged from r=0.004 to r=0.4 with a mean of r=0.14, suggesting that the factors on each scale are independent of the other scales and measure different aspects of anxiety or attitude.

What are trainees' attitudes to psychotherapy with older adults? What are thought to be the most emotionally rewarding and challenging aspects of working with older people?

The trainees were asked whether working with older people provided the opportunity to apply psychological knowledge and rated this from one (not at all) to seven (a great deal). The results can be seen in figure seven:

Figure 7: Trainees' ideas on whether working with older people provides the opportunity to apply psychological skills and knowledge (N=366)



The majority of the trainees (60%, N=224) thought that there was a great deal of opportunity for the application of psychological skills and knowledge when working with older people. The trainees were also asked whether it was necessary to respond differently and with a modified approach when working psychotherapeutically with older adults. Seventy three percent (N=271) of the trainees thought it was necessary to respond differently, 14% (N=52) thought it was not, whilst 13% (N=48) were undecided or did not answer. Those who thought it was necessary to respond differently were asked what factors they would take into account when working with older clients. Their answers were analysed using content analysis, see table eight:

Table Eight: Factors trainees thought should be taken into account when working with older people (Total N=271)

Categories	Percentage of respondents	Rank
Cognitive decline/adjust for memory difficulties/dementia *[memory aids, concentration]*	28%(N=76)	1
Physical health problems/sensory impairment/mobility *[effecting therapeutic work and access]*	27%(N=73)	2
Age differences/cohort effects *[older people have different life experiences, different cultural norms, different values, different life stage, developmental factors and tasks, different needs and goals, societal changes]*	21%(N=57)	3
Psychological mindedness/explaining psychological approach *[less psychologically aware, not used to talking therapies, used to alternative coping strategies, attitude to therapy: alien, suspicion of psychology, more time to explain your role and approach and establish the therapeutic relationship, ability to engage in therapy]*	20%(N=54)	4
Particular problems for older adults *[focus on bereavement, loss, death, less years to live, disability, endings may be an issue, life review]*	14%(N=38)	5.5
May need to adapt to individual regardless of age *[depends on the individual's needs, difficult to generalise, can't make assumptions, use same basic skills with any age group]*	14%(N=38)	5.5
Less directive/more flexible (in time, settings and number of sessions) *[less theoretical, loser boundaries, more concrete, modify record keeping, consider vocabulary used and communication difficulties, less jargon]*	13%(N=35)	7
Allow more time/go slower/consider pace/speed of change	10%(N=27)	8
Age of therapist/transference issues *[Impact of age gap on work in sessions]*	6%(N=22)	9.5
Current socio-economic situation/social support/coping strategies	6%(N=16)	9.5
More life experience *[need longer assessment, have more experience to draw on, coped with crises in the past]*	4%(N=11)	12
Less motivated to change/more rigid/longer history of problem	4%(N=11)	12
Don't know/not sure/no experience of working in this area yet	4%(N=11)	12
Miscellaneous *[including respect, depends on model being used, whether the client themselves requested therapy, the importance of MDT work, existential issues, the difficulty of exploring some issues which may be too traumatic]*	15%(N=40)	–
Missing	5%(N=14)	–

Twenty eight percent of the trainees (N=76) mentioned adapting for cognitive changes including dementia and 27% (N=73) suggested adjusting for physical health problems including sensory impairments and declining mobility: *"hearing and memory problems are more common in old age and they necessitate changes - not age per se."*. Fifty-seven trainees (21%) identified cohort differences: "*I would acknowledge different life stages and that the world was a very different place when they were developing into adulthood*", and the importance of "*taking account of the social, political and cultural context of their lives*". There was also some discussion about the different goals this group may have: "*age can change one's perspective on the type of work one might wish to do in psychotherapy*".

The issue of psychological mindedness was highlighted by 20% of trainees (N=54): "*as a group older clients are likely to be slightly less familiar with psychological models and concepts so one might need to spend longer explaining the rationale for one's work*" and the idea that "*often older people find it difficult to think and work in a psychological way*". A number of trainees suggested older people may be more suspicious of psychologists and psychotherapy, seeing psychological intervention as stigmatising and a sign of weakness.

Fourteen percent (N=38) emphasised the different content of psychotherapy with older people, that therapists "*must look at loss*" and there's a "*need to incorporate life reviews*". The limited life expectancy was highlighted: "*there is not always time to change and do things differently for the client*" as well as the dangers believed to be inherent in this work:

> *"a person's resources seem too fragile to reintegrate at this life stage i.e. if life long defences are undone and a person is left in a mess with a short life time to go (e.g. if 80-85!). People don't have same length of time to do reparation".*

A number of assumptions were made about the experience of old age, that older people were "*more likely to have suffered multiple loss*", that normal ageing involved "*low self-esteem, bereavement etc.*". The reality of people's situations was seen as negating

psychotherapy: "*many were experiencing real life difficulties and psychological treatment couldn't work with challenging their beliefs as they were real e.g. disability, pain, cognitive problems*".

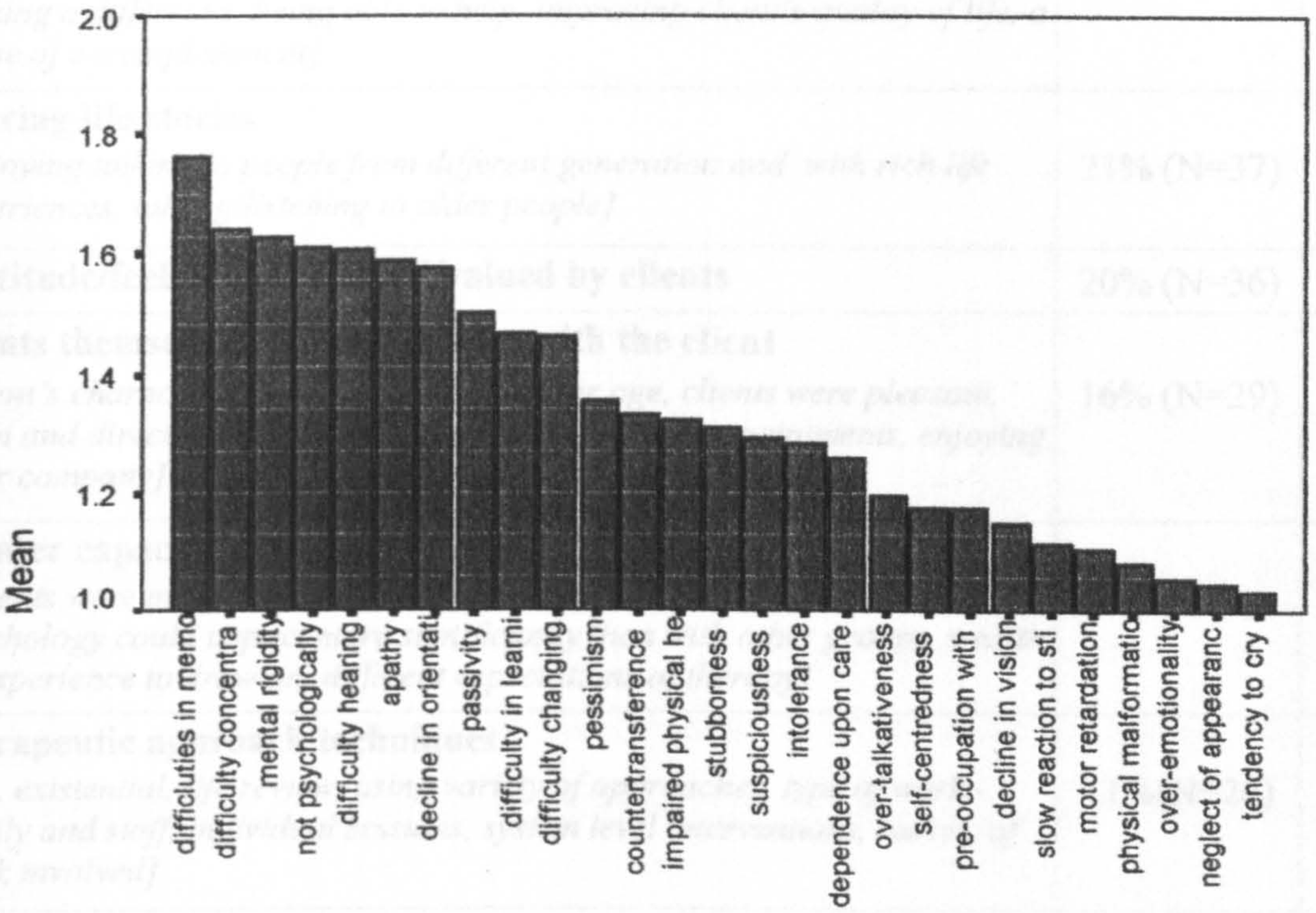
The importance of adapting the therapeutic approach for the individual regardless of their age was mentioned by 38 trainees (14%), including the importance of not making assumptions and generalisations: *"I wonder if you are limiting older adults by lumping them together in one category. I am tempted to say that older adults may have suffered more loss, traumatic life events, may have organic (sensory deficits etc.). However I have worked with younger people who have also suffered from a huge catalogue of events. It's their perception that's important"* and *"each client whatever age is an individual in psychotherapy. There is no particularly universal way to work with people over 65"*.

There was a suggestion that therapists should be more flexible when working with older people in time, place and setting (raised by 13% of the respondents, N=35); that therapists should "*use a story telling approach*" and a "*more 'chatty' approach rather than strictly therapeutic*" also that there should be "*less rigid adherence to boundaries especially regarding personal information*". It was further suggested (by 27 trainees, 10%) that therapists "*need to pace sessions more slowly than with younger clients*" and that a "*longer time is often required to see change*". Twenty two trainees (6%) raised transference issues as areas that should be taken into account when working with older people, for example "*with a younger therapist, issues around this such as envy or being a similar age to children*" and dependency.

Trainees were asked to rate whether the factors on the Psychotherapy with the Elderly scale would hamper therapeutic work with older people, as one: not likely to hamper psychotherapeutic work, or two: likely to hamper this work. Mean scores for each item are shown in figure eight:

Figure 8: Average (mean) score of trainees' views on which of the items of the Psychotherapy with the Elderly Questionnaire may hamper psychotherapeutic work with older people (average N=354)

2	yes, likely to hamper psychotherapy with older people
1	no, not likely to hamper psychotherapy with older people



The trainees' scores revealed that the factors they felt were more likely to hamper psychotherapy with this group (i.e. those factors with a mean score above 1.5) were issues connected to cognitive decline: difficulties in memory, difficulty concentrating and decline in orientation, health issues: decline in hearing (although not vision or impaired physical health), mental rigidity, not being psychologically minded, apathy and passivity.

The trainees who had experience of working with older people during their training were asked about the most challenging and rewarding aspects this work. Their answers were analysed using content analysis and the categories that emerged can be seen in tables nine and ten:

Table Nine: Most emotionally rewarding aspect of working with older clients during training (Total N=178)

Categories	Percentage	Rank
Impact of psychological interventions *[psychological interventions leading to improvements or potential for making a difference, being able to help, improving client's quality of life, a sense of accomplishment]*	40% (N=71)	1
Hearing life stories *[enjoying talking to people from different generation and with rich life experiences, talking/listening to older people]*	21% (N=37)	2
Gratitude/feeling appreciated/valued by clients	20% (N=36)	3
Clients themselves/the relationship with the client *[client's characteristics associated with their age, clients were pleasant, open and direct, polite, friendly, they turned up for appointments, enjoying their company]*	16% (N=29)	4
Greater capacity for improvement *[Clients were more engaged in therapy and more motivated to change, psychology could impact more significantly than with other groups, wealth of experience to draw on, different expectations of therapy]*	12% (21)	5
Therapeutic approach/techniques *[e.g. existential, life review, using variety of approaches, type of work - family and staff, individual sessions, system level interventions, variety of work involved]*	11%(N=20)	6
Changing attitudes - self *[realising change can occur regardless of age, seeing old age more positively, challenging assumptions / stereotypes]*	8% (N=14)	7
Learning from/understanding older adults' experiences *[learning how they have coped e.g. with dementia, their resilience and a lifetime of coping resources]*	6% (N=10)	8
Nothing	3% (N=6)	9.5
Working atmosphere	3% (N=6)	9.5
Practicalities	2% (N=3)	12
Changing attitudes - others	2% (N=3)	12
Don't know/not sure	2% (N=3)	12
Miscellaneous	6% (N=10)	--
Missing	3% (N=5)	--

The most frequently mentioned category (raised by 40%, N=71) was the feeling that their intervention had contributed in a positive way to the person's life, as one trainee

commented: "*the same emotional rewards as working with any client group - being able to help*". Twenty one percent (N=37) referred to the privilege of "*hearing people's stories*".

The gratitude of clients was highlighted as important by 20% (N=37): "*feeling wanted, needed and very welcomed*" and "*they tend to appreciate what you are trying to do, so you feel more helpful and gain more satisfaction*". Sixteen percent (N=29) described the attributes of older adults as rewarding e.g. they were pleasant, co-operative, more tolerant, open and friendly and further: "*they turn up on time and respect your professionalism*". Twenty-one trainees (12%) reported feeling there was a greater capacity for improvement among older clients, since they were more willing to make use of therapy, they were "*more prepared to tackle different issues in therapy*" and they had a wealth of experiences to draw on. Furthermore it was suggested "*often they were not knowledgeable about psychology so there was a lot of scope for intervention*", one trainee reported "*making a change through very simple interventions - but for long standing problems - simply because nothing had been tried before*".

Other rewards reported were the variety of work (both in terms of models, e.g. existential, life review and approaches, e.g. working with clients, carers, institutions etc.) and that working with this group led to challenging attitudes and assumptions (mentioned by 8%, N=14): "*recognising that later life can be fulfilling, enjoyed and/or action-packed!*", the "*realisation that old age isn't necessarily gloomy*", the "*realisation that their issues were issues I had come across in other context - that they were not an 'alien' group to me*" and similarly "*realising that older adults are human beings, not a different species!*".

Six trainees (3%) however reported that there was nothing rewarding about working with this group: "*I felt my experience was very negative*" and for one trainee this was regardless of the positive nature of their placement experience.

Table Ten: Most emotionally challenging aspect of working with older clients during older adult placement (Total N=178)

Categories	Percentage of respondents	Rank
Situation of clients/multiple of losses *[reality of situations, depressing and sad situations, clients facing death, physical and mental deterioration, illness, isolation and social issues]*	28%(N=50)	1
Feeling incompetent/overwhelmed/helpless/hopeless *[feeling unknowledgeable/unskilled/young and inexperienced, slow progress, little possibility of change not enough time left, acceptance rather than change, their feelings of regret, clients behaviour patterns more entrenched, problems were long standing, complex cases, client and therapist feeling "what's the point?"]*	26%(N=46)	2
Working with people with dementia and their families *[witnessing deterioration]*	13%(N=23)	3
Personal impact *[concerns re: own or relatives' ageing and mortality, concerns re: bereavements and dependency in own old age, concerns re: dementia, impact of current personal situation e.g. recent bereavements]*	12%(N=21)	4
Disclosing diagnosis of dementia, carrying out assessments for dementia *[breaking bad news in general]*	8%(N=14)	5.5
Attitudes of others to older people *[shortfalls in services, working with care staff, working in services that didn't meet needs, poor resources e.g. private nursing homes, difficulty challenging the system]*	8%(N=14)	5.5
Perceived difficulties working psychologically with older adults *[client seeing you as their child or a 'young upstart', difficulty introducing psychological ideas]*	6%(N=11)	7
Dominance of medial model/psychiatrists	4%(N=7)	8
Placement/supervisor issues/lack of support	2%(N=4)	9.5
Nothing	2%(N=4)	9.5
Miscellaneous *[including inappropriate referrals and communication difficulties]*	9%(N=16)	--
Missing	3%(N=5)	--

The most frequently mentioned emotional challenge was the reality of the situations of clients (mentioned by 28% of the trainees, N=50). In particular the multiple losses experienced by older people: *"feeling so desperately sorry for them - the loss, death, bereavement, illness,*

poverty, loss of dignity, abuse. Horrible!" and that it is *"hardly any wonder that they have psychological problems with those life events"*. Trainees also identified how ageing can be associated with inevitable depression: *"the realisation that the origins of depression were realistic/largely unchangeable i.e. isolation via death of friends/family, poverty, limited mobility and pain. Finding myself agreeing with clients assessment that "they just keep you alive too long"*. Furthermore the impact on the therapeutic process was emphasised: *"knowing that they were socially isolated and lonely and that to end therapy removes a 'social' contact, therefore trying to ensure other support networks were in place"*.

Twenty-six percent (N=46) mentioned the feelings of hopelessness experienced when working with this group, either because (1) their problems seemed more entrenched, complex or long-standing., (2) the clients were more hopeless: *"when clients seemed to be just 'giving up' and had lost all hope e.g. when challenged in therapy their answers being 'well there's no point, why bother' - it was difficult for me to find appropriate answers"* and *"where to start! So many clients had problems that were long-standing, sometimes helplessness and hopelessness can be contagious"* or (3) there was a limited sense of time: *"the sense of there not being enough time left, that things cannot be undone, seemed stronger in this client group. It was easier to feel hopeless. Whereas with younger clients there is a (perhaps unfortunate) tendency to describe patients as 'difficult' rather than 'hopeless'"*, another trainee commented it was *"easy to feel it isn't worth doing things as there's limited time - not slip into thinking a client is bound to be depressed, they're old"*. Further in this category one trainee mentioned the *"feeling that I wanted to 'care for' or 'look after' some clients who appeared particularly needy"* whilst one commented on their *"inability to make them young again"*.

Other emotionally challenging aspects of the work included working with people with dementia and their families (13%, N=23) and the feelings of hopelessness that can be associated with this work: *"facing the fact that in some cases there is nothing we can do to prevent the horrific deterioration caused by organic disease"*. Twelve percent (N=21) mentioned the personal impact of the work and the *"discovery that old age doesn't imply*

psychological well being". Three quotes will be used to highlight this: (1) the "*recognition that all life has to come to an end and how unprepared I feel for facing this. Finally watching some clients lose their independence and becoming dependent on others (especially medics) fills me with dread*", (2) "*on a personal level, it can be difficult to work with clients who have been 'psychologically well' for most of their lives as they struggle to come to terms with increased dependency, loneliness, poor physical health and impending death - issues that'll face all of us and issues that are mirrored in our parents or grandparents' lives*" and (3) "*recognising that if everything goes 'well' in my life - I could still live to 85 years and my husband dies and I'm left alone - deterioration physically and mentally*". Furthermore the impact of this placement in terms of older relatives was described e.g. "*throughout training I have had two very close family members diagnosed with terminal illness - I found that working with older adults reminded me of my personal distress and I felt too 'wobbly' to confront a whole older adult placement*".

Also mentioned in response to this question were the feelings of hopelessness around service delivery, the attitudes of other professionals and feeling powerless to make any changes (8%, N=14) and the medicalisation of client's problems by other professionals, clients and relatives (4%, N=7). However 2% (N=4) reported they had not found any aspects of their experience of working with older adults emotionally challenging.

Why might it be difficult to recruit and how might recruitment to this specialty be improved?

The trainees were asked to comment on why it might be difficult to recruit to the older adult specialty and how recruitment could be improved. Their answers were analysed using content analysis and the results can be seen in tables eleven and twelve.

Table Eleven: Why trainees thought it may be difficult to recruit to the OA specialty (Total N=371)

Categories	Percentage	Rank
Less positive outcomes/significant improvements are less likely / less rewarding/less impact of psychological approaches *[less opportunity to work psychologically, limited capacity for change, client and/or therapist's view that there's little time to benefit due to decreased life expectancy, clients not psychologically minded, clients are more rigid and problems more entrenched, clients deteriorate and may have long term problems or more complex problems, progress can be slow, hard and challenging work]*	45%(N=167)	1
Personal issues *[facing ageing, death, bereavements, emotional challenge, difficult to relate to people from this age group, clients more likely to die, depressing work, fears of ageing, impact on trainees' current life circumstances, people's perception that the work is all loss and death, dementia and depression]*	43%(N=160)	2
Unattractive specialty/poor image/low profile *[low status, not cutting edge, not as glamorous, fashionable or sexy as other specialties, dislike of client group, not exciting or challenging or dynamic, lack of kudos, unpopular in comparison to other specialties]*	36%(N=134)	3
Ageism/prejudice/old age bias *[attitudes to older people, marginalisation in wider society, stereotypes]*	22% (N=82)	4
Training/experience issues *[lack of experience, bad placement experience, timing of placement, shortage of placements, poor quality teaching]*	16% (N=60)	5
Work environment/work with families, carers &organisations *[services not well developed or of poor quality, depressing environments]*	15% (N=56)	6
The work is mainly neuropsychological assessments/limited role *[lack of variety in work, emphasis on neuroassessment rather than psychotherapy: either a belief that this is the case or past experience which has born this out]*	12% (N=45)	7.5
Supervision/lack of support/few good role models *[too few psychologists working in the specialty, isolation, smaller departments]*	12% (N=45)	7.5
Limited resources and lack of funding	10%(N=37)	9.5
Psychological models/therapies haven't been applied *[theories not as well developed, less research]*	10% (N=37)	9.5
Medicalised/non psychological philosophy *[limited therapeutic ethos, older people's psychological needs aren't recognised]*	9% (N=33)	11
Poor opportunities for professional development *[reluctance to become too specialised, 'boxed in' to older adult specialty]*	5% (N=19)	12.5
Don't know/not sure/unaware it was an issue	5% (N=19)	12.5
Miscellaneous	14% (N=52)	--
Missing	3% (N=11)	--

Just under half of the trainees (45%, N=167) thought recruitment may be problematic because of the perception that psychological approaches have less impact with older clients. Older people were suggested to be more resistant or unable to change, inflexible to new ideas and rigid. It was thought they had reasons to be depressed or anxious which made "*complete cures*" unlikely; there was a "*perception that change is pointless - there's little time to benefit*" and further "*ultimately they die so what's the point?*". Trainees felt less clear about the role of psychologists with this age group: "*feeling that older people's lives, filled with bereavement, failing faculties and limited opportunities, are inherently depressing - so what can one do?*" and rather more extremely "*the view that nothing can be done for someone in their seventies*". The feelings of many are summarised by the following quote: "*overall the problem is that psychologists like to feel they can effect change and this is challenged by this population*". There was also an acknowledgement that such pessimistic attitudes to therapeutic change were also owned by clients themselves: "*maybe trainees 'buy into' older person's dysfunctional assumptions i.e. I'm too old to change etc.*" and this can be seen as part of our cultural language when trainees described the difficulty of teaching "*old dogs new tricks*" and asking "*can a leopard change its spots?*".

Personal issues were reported by 43% (N=160) as being a barrier to recruitment: "*perhaps there is a general dislike of staring one's own mortality in the face every day*". The work was described as overwhelming, depressing and distressing and that working with older people forces trainees to face issues such as ageing, ill health, dementia, dependency and death when "*one is young, well, near the beginning of life - it's not nice to be reminded that this won't always be the case*". However it may be that trainees had been primed to think about these aspects as one wrote "*having read your covering letter, maybe it's about ageing and death fears*".

Thirty-six percent (N=134) raised the idea that both the specialty and older people themselves are seen to be unglamorous, 'unsexy' unexciting, unchallenging, not 'cutting edge',

unfashionable, unstimulating and they have a poor profile: "*It doesn't have the same status as other areas. I think it is viewed as less innovative and less dynamic*" and that they are "*not important enough - near the end of their lifespan*". In terms of the image of older adults one respondent wrote that the "*image of dribbling demented OAPs in institutions is off putting*" and another that it was only "*talk about gardens, tea and the war*". Following on from this 22% (N=82) thought that "*pure ageism*" may be responsible for difficulties with recruitment, that older adults were a "*low status group who aren't valued by society and seen as a burden*" and they were further "*subject to the same societal stereotypes of boring, rambling, cantankerous, incontinent etc., etc.*". They suggested that psychologists themselves may feel devalued by association with this group.

Training issues were mentioned by 16% of the trainees (N=60) as another factor affecting recruitment. Many felt that older adults were given a low priority during training and that both the placement and teaching were of poor quality. Specifically the lack of placements and the timing of placements were raised as important issues: "*the training appears to push the older adult placement to the end of the course. Not having any older adult experience means I am less likely to consider the area as a research topic and less likely to be planning for my first job in the area*" and that it is "*hard to get enough experience to know you want to go into that area*". Further the quality of supervision was thought to be low by some trainees: "*due to shortage of psychologists in this specialty, courses have to 'scrape the bottom of the barrel' to find supervisors*".

Fifteen percent (N=56) blamed poor quality services, "*a dearth of dynamic health workers*" and depressing environments for the lack of recruitment. Whilst 12% (N=45) felt that psychologists had a limited role when working with older adults and specifically that the majority of the work was neuropsychological assessment and behavioural work, with less opportunity for psychological interventions. Others mentioned isolation and lack of support as well as few good role models in the specialty: "*older adult services are full of lousy*

psychologists" and further "*traditionally it was seen as a field that less gifted psychologists went into*".

There was a belief among 10 % of the trainees (N=37) that the older adult specialty offered little opportunity for research or application of psychological models: "*traditionally viewed as unable to apply therapeutic models*", whilst 10% (N=37) believed the domination of the medical model was detrimental to recruitment. A further issue raised was that trainees may feel there is less opportunity for both professional and personal development within the older adult specialty and one trainee asked "*is there a 'way out' if new comers decide against working in this specialty? I suspect it's easier to move into than away from so you need to be very confident about your decision*".

Table Twelve: Trainees' thoughts on how recruitment to the older adult specialty could be improved (Total N=371)

Categories	Percentage	Rank
Good quality older adult placements and/or teaching on training courses *[maintaining core experience of working in older adult specialty, changing timing of older adult placement, ensuring good quality of placement and teaching, emphasising a variety of work in teaching, encouraging positive attitudes, encouraging research by trainees]*	45%(N=167)	1
Improved marketing of the role of older adults psychologists *[more accurate information, increased knowledge re: working with older adults, changing nature of work, changing way services are valued, variety of work, role of clinical psychology, what are positive aspects of working with older people, what improvements and changes can be made, more research]*	39%(N=145)	2
Improved terms and conditions/more support *[posts are more attractive as more posts are filled, opportunity for research and CPD, support of professional and personal development, more contact between psychologists, developing specialist interest groups e.g. PSIGE, combat feelings of isolation]*	14%(N=52)	3
Don't know / not sure	12%(N=45)	4
Higher pay/more funding for posts	11%(N=41)	5
More split posts	9%(N=33)	6
Better resources/working conditions *[quality of services to older adults, more funding for services, more resources, improving environments]*	6%(N=22)	7
Changing in society's attitudes *[tackling ageism, more positive role models in media, psychologists' role in terms of education and training, more positive social representations of older age]*	6%(N=22)	7
Changing service organisation *[is a specialist older 65 service necessary?]*	5%(N=19)	9
More Assistant Psychology posts *[higher quality AP posts with good supervision, positive experiences as APs]*	5%(N=19)	9
Making services more psychological/less medicalised	2%(N=7)	11
Miscellaneous	9%(N=33)	--
Missing	7%(N=26)	--

As can be seen in table twelve, the areas most frequently mentioned in terms of improving recruitment to this specialty were providing good quality placements and teaching

(45%, N=167), improved marketing of the role of older adult psychologists (39%, N=145) and improving the terms and conditions (14%, N=52).

Summary of main findings

The main findings can be summarised as follows:

1. The older adult specialty was the fifth most popular specialty among these respondents, furthermore it was the third most popular of the core specialisms.

2. Three of the independent variables were significant predictors of the dependent variable: interest in working with older people on qualification, these were (1) interest in working with older people prior to training, (2) AAS: fear of old people and (3) experience of working with older people during training. Together these variables accounted for 33% of the variance in the dependent variable.

3. The trainees' age, their attitude to older people and their level of death anxiety were not significant predictors of their interest to work in the older adult specialty.

4. Trainees' interest in working with older people prior to training was predicted by experience of working with older people prior to training and the AAS: fear of old people. These two independent variables accounted for 23% of the variance in the dependent variable.

5. Examinations of reliability suggested many of the factors possessed poor reliability over time and that the AOS in particular showed poor internal consistency. However the factors did appear to measure independent constructs.

6. This group of trainees stated they were currently more likely to want to work with older people than they were prior to training.

7. Following on from this, trainees seemed to be rate themselves as more likely to want to work with older adults once they had experienced working with this group during training. However this may have been affected by the fact that the quality of both placements and supervision during training was rated highly.

8. Approximately three-quarters of the respondents (73%) thought it was necessary to respond differently and with a modified approach when working with older people. Factors which they thought should be taken into account included the cognitive ability of the clients as well as their physical health, accounting for cohort differences and psychological mindedness.

9. The emotional rewards of working with older people included having a positive impact, hearing their stories and feeling appreciated. The challenges described included the situation of the clients, feeling incompetent and the personal impact of the work.

10. Respondents felt there might be low recruitment to this specialty because significant improvements are less likely, the impact of personal issues and the unattractive image of the specialty. In terms of improving recruitment trainees mentioned providing good quality teaching and placements, improved 'marketing' and improved terms and conditions.

Discussion

The discussion will consider the results and suggest provisional explanations for the findings. The clinical implications are examined particularly in terms of recruitment to the older adult specialty. The limitations with this study are explored and ways forward suggested.

Motivation to work in the older adult specialty

Adult mental health and child services were found to be the most popular specialties, which supports previous findings among both qualified and trainee clinical psychologists (e.g. Lavender, 1993). However, contrary to previous studies, the older adult specialty was found to be more popular than learning disability services; previously it has typically been reported as the least popular of the four 'core' areas (e.g. Thomas & Cook, 1995; Scott, 1997). This may reflect either (1) a shift in trainees' interest i.e. they are becoming more interested in working in this specialty, or (2) given that the research was focused on older adults, there may be a response bias, in that trainees who were more interested in working in this specialty may have been more likely to complete the questionnaires. The possibility of such a response bias needs to be held in mind when considering the results of this study.

Predictors of interest to work with older adults

Attitudes towards older people

It was perhaps surprising that attitudes to older adults as measured by the AOS were not a significant predictor of interest to work in this area given the literature reviewed (e.g. Saarela & Viukari, 1995) However, there are some doubts as to the reliability of this measure which will be discussed in a later section. The results suggest that these trainees had generally positive attitudes to older people (i.e. 99% of the mean scores were less than five on the scale of one to nine, lower scores indicating higher perceived social value of the elderly). This may

reflect either (1) the fact that trainees hold generally positive attitudes towards older adults, which supports Gatz & Pearson's (1988) suggestion that global negative attitudes towards older people may have been overestimated among mental health professionals or (2) the scale may be open to social desirability bias with the result positive attitudes were overestimated.

Ageing anxiety

Only one of the factors from the AAS, the fear of old people, was found to be a significant predictor of trainees' interest in working with older people. Respondents who were less 'fearful' on this scale being more likely to be interested in working with older people. According to Lasher & Faulkender (1993) this factor assesses "external contact" with older people and "taps anxiety about ageing in an individual who may be more defensive about aging anxiety" (p.257). Unlike the other three scales of the AAS it does not directly relate to anxiety about one's own ageing. They believed that individuals who dealt with anxiety about ageing through the use of denial or reaction formation may reveal anxiety on this factor, while it remained denied or hidden on the other more direct factors. Therefore these results could suggest that people who dislike external contact with older people, which may be part of a defensive manoeuvre to avoid painful feelings about growing older, are less likely to want to work with older people.

Trainees concerns about psychological issues related to ageing, their fears over their physical appearance and their general fears of loss associated with ageing (as measured by the AAS) did not significantly predict their interest in working with older people.

Death anxiety

Levels of death anxiety as measured by the MFODS also failed to predict motivation to work with older people. This may be an artefact of the fact that death anxiety scales solely measure conscious anxiety (Wass et al., 1985). It has been argued that many individuals attempt to repress feelings of death anxiety (Firestone, 1994). Therefore, death anxiety may in fact not be a relevant factor in determining interest in working with older adults. On the other hand,

since the MFODS is not sensitive to unconscious death anxiety, these untapped unconscious feelings may still impact significantly on choice of specialism. Statements from a number of trainees may lend support to this view: they described that although not fearful of the statements in the MFODS on a daily basis, they had some concerns about the issues. One respondent wrote: "*I would not want to die slowly, but it is not something I worry about*".

Experience of working with older adults

The most important predictor of trainees' interest in working with older people on qualification was their interest in working with older people prior to training. Therefore perhaps trainees' interest in working with older people can be determined by their interest in this area at the time of their clinical training interview, as has previously been suggested by Lavender (1993). As a means of increasing supply, Lavender (1993) suggested asking candidates at selection interviews whether they were interested in working in particular specialisms, however he also reports this method can be problematic.

The third significant predictor variable of trainees' interest in working in the older adult specialty was trainees' placement experience (The second significant variable has already been discussed, see p. 63). Trainees who had had some experience of working with older people during their training placements (whether in a specialist older adult service or more generally) were more likely to be interested in working in this area on qualification. This would seem to lend credence to the argument that placement experience can encourage trainees to think about working with older people (e.g.. Britton & Woods, 1996) and highlights the importance of maintaining experience of working with older people during training. Further analyses examining the impact of *specific* older adult experience (i.e. placement experience working in a service specifically dedicated to older adults) was complicated because of the small number of people who gained their older adult experience in other services e.g. adult and rehab. This made it difficult to consider the impact of the core placement debate in terms of recruitment.

Trainees' pre-training experience (i.e. whether they had experience of working with older people prior to training as measured on a dichotomous scale - yes/no) failed to significantly predict their interest in working with older adults on qualification. However further analysis found this pre-training experience was a significant predictor of trainees' interest to work with older people prior to training. That is, people who had had experience of working with older people prior to training were more likely to express a preference to want to work with older people prior to training. The open questions however revealed previous experience/previous work as the most frequently mentioned factor in determining choice of specialism (mentioned by 45% of trainees, N=168); also significant was training/placement experience (37%, N=138). Thus pre-training experience may be more relevant when deciding to work in other specialties than with the older adult specialism. Furthermore the study did not distinguish between negative and positive experience, both of which could have influenced decisions in different ways.

On further questioning trainees reported that they were more likely to want to work with older people after having had experience of working with older people during training (which supports the findings from the multiple regression). Furthermore, they appeared to be more likely to state a preference to work with older adults during, rather than prior, to training. Thus there appears to be a shift during training when the older adult specialty becomes more attractive. This shift may occur because training has provided the experience to work with older adults on placement and teaching experience in the area. However, this sample tended to rate both the quality of their placement and the quality of their supervision when working with older people highly. This may be a sample bias or could be a reflection of the overall high quality of placements and supervision in this area. The possibility of a biased sample needs to be taken into account when analysing these results. These respondents may have experienced placements that were of better quality than the average placement and this could impact on the generalisability to other trainees.

Research evidence suggest that more contact with older people leads to a better understanding of the ageing process and psychological ageing (Peterson, Hall & Peterson, 1988). Trainees who experience working with older people during training may further have the opportunity to challenge their previous attributions and attitudes to this client group. A number of trainees in this study suggested that either teaching or training experience had offered the chance to address their stereotypes and the societal myths about old age.

Age

Age was similarly not found to be a significant predictor of interest to work with older people. This may have been related to the fact the respondents' overall age range was not large (89% were aged between 23 and 33). Furthermore it may be that other factors that are associated with age but not equivalent may be more relevant factors, e.g. length of work experience or cohort issues.

Attitudes to psychotherapy with older adults

In general the trainees thought that psychological skills and knowledge could be well used with this age group, however the majority thought some modifications would be necessary. The results suggest that Freud's legacy of scepticism as to the value of psychotherapy with this group may have some relevance with this group of trainees. As measured by the Psychotherapy with the Elderly scale, 61% (N=224) of trainees thought that older adults' mental rigidity may hamper psychotherapy, whilst 57% (N=211) thought lack of psychological mindedness may be a hamper and 45% (N=168) thought older people's difficulty in learning new things could be problematic. However, when asked to comment more openly on the factors which should be taken into account when working with this group, only 20% (N=54) mentioned psychological mindedness and 4% (N=11) rigidity; more frequently mentioned were physical health problems and cognitive abilities. A further factor which trainees raised was cohort differences. This has been reflected in the current literature, for example, Biggs (1993) argues that age confers different priorities and existential projects.

Whilst a small percentage of the trainees (14%, N=38) commented on the importance of working with the individual regardless of their age, others clearly held assumptions about psychotherapy with older people. For example, in terms of cognitive decline, some trainees recognised the individualised nature of the impact of ageing on cognitive abilities and that dementia was not ubiquitous. Others, however, appeared to assume that cognitive decline was universal among older adults.

Most emotionally rewarding aspects of working with older people during training: The most frequently mentioned category (40%, N=71) was trainees' feeling that their intervention had contributed in a positive way to the older person's life. It is likely that this is an important issue in therapeutic work with all client groups and may be related to therapists' unconscious desires to be needed and appreciated. This issue may also be reflected by the 21% (N=37) of trainees who mentioned the importance of being appreciated and valued by their clients.

Most emotionally challenging aspects of working with older people during training: In contrast, the issues that trainees seemed to find particularly challenging revolved around feelings of hopelessness, feeling overwhelmed by older people's situations and their experiences of multiple loss. This appeared to be a more important factor than trainees' concerns about their own mortality and ageing. This relates to the findings highlighted in the introduction, that feelings of anxiety can be aroused by the dependency needs of older clients (Martindale, 1989; Yesavage & Karasu, 1982). This is an important issue for placement supervisors and training courses to acknowledge and allow trainees space to explore these issues in supervision or teaching. Furthermore, when considering these issues Dick, Gallagher-Thompson & Thompson (1996) suggest that a "younger therapist must also consider whether they can tolerate the nature and complexity of problems that some older adults bring to treatment" (p.518).

Recruitment

Why might it be difficult to recruit

Although there "has been a massive leap in the basic understanding of the processes of ageing, in the development of useful models and in evidence based and effective intervention" (Britton, 1999, p.7), there continues to be a feeling that psychology has less of an impact with this client group, which is reflected in the findings from this study. This may in part be due to the tendency for older people to be under-represented in published psychological studies, which is reported by Bender (1986) in his article "The neglect of the elderly by British psychologists". It has also been suggested that there is a tendency for early life to be over-emphasised within psychotherapeutic models. Echoing other contemporary theorists Nemiroff & Colarusso (1985) argue that Western thought has been ingrained with the notion that the first six years of life explain the majority of behaviour. They emphasise that growth and development take place in late life and have developed a psychodynamic theory of adult development during the second half of life. Furthermore Erikson et al. (1986) provide information to support the notion that the resolution of conflicts from earlier life stages is possible in late life.

Personal issues were also suggested as a barrier to recruitment; there was a perception that the work was all "loss and death". Biggs (1989) reflects that the helper's own phantisised personal future is likely to be negative, given the nature of social stereotyping and the skewed circumstances in which older people and the helping professionals generally meet. Another important area mentioned by the trainees was that the older adult specialty is unattractive. There were further suggestions that older people themselves were also unattractive and unappealing and that psychologists working in this field may be devalued by association.

It is important to comment that many of the issues raised were suggestions as to why others may not want to enter the older adult specialty and therefore reflections of others' prejudicial views. Therefore it is difficult to ascertain whether these thoughts were actually reflected in

this group of trainees or are generalisable to others. Ultimately they are trainees' thoughts as to what might hamper recruitment to the older adult specialty rather than why *they* had chosen not to work with older people.

How could recruitment to the older adult specialty be improved?

The issues trainees raised with respect to improving recruitment will be discussed in terms of the implications for training courses; clinical psychologists working within the specialty and for older adult services in general.

Training courses

Trainees thought training courses should provide the following in order to improve recruitment to this specialty:

(1) a greater emphasis on working with older adults during training

(2) good quality older adult teaching e.g. more co-ordinated teaching, with a focus on the possibilities for change through therapy; encouraging a life-span perspective; emphasising similarities to as well as differences from work with other groups and encouraging a focus on normal ageing, asking older adults to speak on courses about successful ageing or how they found contact with a clinical psychologist helpful

(3) providing good quality placements

(4) 15% (N=56) emphasised the importance of maintaining/providing a compulsory older adult core placement; it was thought that this would allow trainees the opportunity to learn from experience and gain confidence in this area and would provide "*a valuable opportunity to challenge ageist assumptions and to experience how rewarding it can be to work with this client group*". However the difficulties of providing such placements were also acknowledged: "a *good placement appears crucial, but how this can be achieved given the difficulties re: shortage of supervisors I don't know*"

(5) to address and challenge trainees' beliefs and assumptions about working with this group "*the teaching I have received on my course has already challenged some of my personal*

opinions of working with the elderly. I would have enjoyed the opportunity to gain experience in this area, so that I could make up my own mind"

(6) ensuring that there is a member of course staff with a dedicated interest in the older adult specialty

(7) changing the timing of the older adult placement, as it often appears to be the last core placement for many trainees

(8) providing the opportunity to discuss the personal impact of working with older adults during training e.g. *"fears re: death, ageing and dependency*".

Clinical psychologist working within the specialty

The following ideas were mentioned:

(1) marketing: promoting/publicising the work of clinical psychologists in this area; promoting the positive aspects of work as well as the challenges; promoting innovative work; improving the recognition of older people's needs; emphasising how psychological input can be useful; raising the profile of the specialty; highlighting and encouraging research in this area

(2) increasing pre-training experience by negotiating more assistant psychologist posts

(3) educating society; trying to alter wider social attitudes to older people.

Further to these ideas Britton & Woods (1996) recognise that recruitment has been greatly helped by the enthusiastic and supportive network of psychologists working in this area, e.g. PSIGE.

Older adult services

Several categories reflected more service level issues:

(1) better resources and working conditions

(2) more split posts

(3) improving opportunities for CPD and personal development, research opportunities, opportunities for promotion, improving professional support networks especially for newly qualified psychologists

(4) increasing funding for psychologists posts and for improving services

(5) integrating older adult services into adult services with specialists in dementia alongside a recognition that 65 years is an arbitrary cut-off point and that this may encourage the development of a marginalised and under resourced "Cinderella service".

With reference to the last point, the debate about the appropriateness of a specialist or generic older adult service has been ongoing in the literature (e.g. Howells, 1992). Woods and Roth (1996) suggest that:

> *"the purpose of treating this group separately rests on two considerations: (1) that the anticipated response to psychological interventions in the elderly cannot be assumed to be the same as in younger adult samples in the same way as the efficacy of treatments of childhood disorders is normally considered separately from the impacts with adults; and (2) that the higher prevalence of organic problems often complicate the application of psychological interventions and hence necessitates separate evaluation" (p.321).*

However Howells (1992) argues that even if elderly people would stand to gain a better service from specialists, if clinical psychologists cannot be persuaded to join the service they may in reality, get a worse service. Furthermore providing a separate service for older adults could in itself be interpreted as ageist.

It may have been informative to compare the answers of those who were and were not interested in working with older adults in terms of their opinions about recruitment and their attitudes to psychotherapy with the elderly. However time restrictions made this impossible.

Similarly the views of those who had experienced working with older people during training could have been compared to the views of those who had not.

Implications for clinical practice and training

The ideas concerning recruitment suggested by the trainees are summarised above. Given the current political and cultural climate some ideas are more realistic than others. However the research highlights the need to encourage trainees to develop an increased knowledge about ageing, the developmental issues in late life and normal versus pathological ageing. The suggestion of ensuring that teaching focuses on successful ageing would be helpful in redressing the balance of clinical work. Training course must recognise the importance of helping trainees to obtain a greater understanding of the strengths, weaknesses and complexities of older people. Others have examined how training in this area could be improved e.g. Larner (1986) suggests the following ten core areas for inclusion in clinical training:

1. The need to be aware of current research on normal ageing
2. Theories of ageing, making reference to the "new" concepts of life-span development
3. Avoiding mythology and stereotyping
4. The need to effectively "tailor" interventions for older adults
5. Awareness of service planning and staff training models
6. Ability to work in a range of settings
7. Ability to relate to multidisciplinary others
8. The problems of secondary referral (often with little awareness by the client of referral)
9. Possible staff burnout and demoralisation
10. The impact of death and its anticipation on the practitioner, carers and client.

A number of studies have questioned the impact of training programmes on practitioners, demonstrating a mixture of results. Awareness that stereotypes are present has been found to diminish their influence on the attitudes of first year medical students (Wilson & Hafferty,

1983). However, following a review of the early literature, McTavish (1971) concludes that the impact of training on changing attitudes towards older people are equivocable and another study shows a negative shift with training (Treharne, 1990). Furthermore, although training may positively influence attitudes, it may ultimately not encourage trainees to enter into the older adult specialty. In a study of student nurses Dellasega & Curriero (1991) found that although their programme improved student nurses' attitudes towards older people, the programme did not change their preference not to work with this age group. These studies bring into question the effectiveness of training in terms of influencing trainees' attitudes and their decisions to work with older people. Further research would be needed to examine the influence of any of these ideas on increasing recruitment to the older adult specialty.

However, in my opinion, given the growing number of older people, this area needs to be promoted within clinical psychology in the UK. The American Psychological Association has already made moves to prioritise services to older adults (APA, 1999). Furthermore within the UK, Eweka (1994) has argued that the time is right for 'positive action' in respect of counselling for older people and he further suggests the need for a Division of Geriatric Counselling within the British Association for Counselling. Given that this is the UN Year of the Older Person, it would seem an apt time to take the positive action that is necessary to prioritise older adults during clinical psychology training. The potential for increasing the status of this field of practice is considerable and essential, as highlighted by Litwin (1994) "given the requirements .. to meet the needs of an increasingly ageing society, serious attention to address this task is, indeed, warranted" (p.68).

Limitations of this study

The response rate (41%) was to be expected given that the study was a postal survey. However it is unclear the extent to which the findings can be generalised to other clinical psychology trainees. Those who responded could have had a more positive or negative perception and/or experience of working with older people. However although some caution

is necessary, the relatively large sample size (approximately a third of all current trainees) makes generalisations more confident.

It is essential to remember that attitudes cannot be equated directly with behaviour and therefore it cannot be assumed that trainees' stated preference to work with older adults translate into their actually working in this specialty on qualification. This was highlighted in Scott's (1997) study where, although 57 percent of the trainees commented that they would consider a career in the older adult specialty, only 6 percent (3 trainees) had taken a post in this area. A longitudinal study would enable the researcher to assess how often trainees' expressing a preference to work in the older adult specialty chose to work with this group on qualification. Furthermore, the assessment of pre-training preference was retrospective. A longitudinal study would allow for more valid recording of this variable at the time.

Additionally the researcher needed to consider the impact of her "positioning" (Salmon, 1996) particularly when interpreting the results of the content analysis. Krippendorff (1980) comments on the process of self-sampling, choosing perhaps unconsciously what will be included in their answers. This issue is particularly important as the researcher is a current trainee who has some interest in working with older adults. To counter this, and given more time, another researcher could have used the data to develop another set of coding frames and note the similarities to and differences from the originals. A further method would be respondent validation, where coding frames could be sent to the trainees to assess their validity.

Ethnic origin was not included in the analysis since the ethnic origin of many respondents was unclear from the data received e.g. a number of respondents answered "British" and "Caucasian". However it seems that this area is important to follow up as the number of older people from ethnic minority groups is rising in the UK, although the percentages remains considerably less than the white population. Among the Indian population and the

Black/Caribbean population it is five percent and two percent among the Pakistani/Bangladeshi community (Manthorpe, 1994).

The Measures

The measures in this research have not been widely used and this limits comparison with earlier studies using different measures. The influence of social desirability on all the scales needs further investigation Social desirability could have an effect as trainees may have attempted to answer in a non-prejudicial manner.

The theoretical underpinnings of the scales must also be examined. Following a review of the empirical papers dealing with death anxiety, Neimeyer (1995) reported a relative weakness in the theoretical justification of the research strategy in this area. Tomer (1992) has begun to address the lack of theoretical underpinning by reviewing both philosophical and psychological approaches, in order to begin to form an integrated theory of death anxiety. However, as with ageing anxiety and ageism, there is a lack of theory with these constructs.

Other limitations of this study include the Christian/Western ethic of the questionnaires, which has been previously highlighted by Long (1985/6) with reference to the MFODS. This was mentioned by a number of respondents e.g. "as a Hindu I see death as a continuation of life. The soul lives on to take another body." Another issue was that such measures can tend to appeal to generalised notions of ageing and may not reflect respondents' genuine reactions when individual older people are actually encountered (Crockett & Hummert, 1987; Gatz & Pearson, 1988). Lastly a few respondent questioned the relevance of some of the items e.g. Item 41 of the MFODS, "I am afraid I may never see my children grow up" was not relevant to many trainees.

Reliability and validity of the scales

The lack of any correlations above r=0.4 between the measures of the scales suggests they measure fairly independent factors: i.e. death anxiety, anxiety about ageing and attitudes

towards the social value of older people are distinct entities as measured in this study. In terms of internal consistency a number of the scales had such low Cronbach's alpha scores that their reliability must be questioned, in particular the AOS and the fear of the unknown factor of the MFODS. These low alpha coefficients suggest that the test items within these factors are not consistent with each other and calls into question whether they are measuring what they purport to measure. Furthermore the measures of test-retest reliability suggested that the majority of the factors have a poor reliability over time. These findings need to be taken into account when interpreting the results. This is particularly true of the AOS; it is not clear whether attitudes to older people are not significant predictors of interest to work in the older adult speciality, since these results suggest the different items of the AOS are not measuring the same factor.

Further research

Other issues that could be explored include:

1. Further investigation into other factors that might act as barriers to older people receiving psychology services other than lack of motivation among professionals. For example the attitudes of older people towards psychology services and their ideas on how to make services more accessible.

2. Exploring other factors which may be influential in predicting motivation of professionals to work with older people e.g. quality and quantity of contact with older adults, religious beliefs, experiences of bereavement etc.

3. Empirical studies have suggested there is actually a wide variety of attitudes toward death, which can range from extreme degrees of fear to a complete acceptance and a welcoming of one's own death without fear or anxiety (Greene, 1983). Further studies could investigate the impact of death acceptance or death related coping skills on interest to work with older clients.

4. Comparing the responses of trainee psychologists with other professional groups e.g. qualified clinical psychologists, nurses etc.

5. Exploring trainees' attitudes to psychotherapy with other client groups as well as identifying what they find emotionally challenging and rewarding about working with these groups; then examining the differences and similarities.

Conclusion

This study does not fully support Kastenbaum's (1963) idea of the reluctant therapist, although working with older people was found to be less popular than work with adults and children. Overall ageism, in terms of discrimination against older people solely on the basis of their age, was evident although it must be acknowledged that the study was set up to encourage people to generalise about people over 65 years of age. However there were many negative stereotypes among trainees and in terms of Dixon & Gregory (1987)'s myths associated with old age, the myths of ill health, mental deterioration, inflexible personality, misery and dependence were all mentioned.

Trainees clearly stated pessimistic views about psychotherapy with older people, that it may be unsuitable and inefficient as has been reported by other health care professionals (e.g. Ray et al., 1985, Saarela & Viukari, 1995). However the view that older adults were more willing and had a greater capacity to change was also discussed (Hildebrand, 1982; Nemiroff & Colarusso, 1985).

Trainees suggested a number of ideas as to how recruitment could be encouraged, primarily by prioritising the older adult specialty during training and improved 'marketing' from qualified clinical psychologist working in the area. An emphasis on normal and successful ageing may also prove helpful, encouraging a more balanced view of older people (Shura, 1974). With the increasing number of older people in Britain, clinical psychologists should be concentrating on encouraging trainee psychologists to work with older people, taking on board some of the useful ideas that these trainees have raised.

References

Abell, N. & McDonnel, J. (1990). Preparing for practice: Motivations, expectations and aspirations of the MSW class of 1990. Journal of Social Work Education, 26, 1, 57-64.

Abraham, K. (1919/1953). The applicability of psychoanalytic treatment to patients at an advanced age. In S. Steury & M. I. Blank (Eds.) Readings in Psychotherapy with Older People. Washington DC: Department of Health Education and Welfare.

American Psychological Society (1999). APA advocates are speaking out on a range of issues. Here's a wrap-up of the initiatives they support. APA Monitor, 30, April, 4.

Arean, P. A., Perri, M. G., Nezu, A. M., Schein, R. L., Christopher, F. & Joseph, T. X. (1993). Comparative effectiveness of social problem solving therapy and reminiscence therapy as treatments for depression in older adults. Journal of Consulting and Clinical Psychology, 61, 1003-1010.

Arie, T. (1981). Health Care of the Elderly. London: Croom Helm.

Ashcroft, J., Callanan, M. Adams, M. Roth, T. Gray, I & Lavender, T. (1998). Clinical psychology training and the core placements issue: Ways forward. Clinical Psychology Forum, 112, 50-53.

Ashcroft, J. & Callanan, M. (1997). Clinical psychology training: The end of core placements. Clinical Psychology Forum, 108, 41-42.

Bachelder, J. (1989). Effectiveness of a stimulation activity to promote positive attitudes and perceptions of the elderly. Educational Gerontology, 15, 363-375.

Becker, E. (1973). The Denial of Death. New York: MacMillan.

Bender, M. P. (1986). The neglect of the elderly by British psychologists. Bulletin of The British Psychological Society, 39, 414-417.

Berelson, B. (1952). Content Analysis in Communications Research. New York: Free Press.

Berezin, M. A. (1977). Psychodynamic Considerations of Aging and the Aged: An Overview. In S. Steury & M. L. Blank (Eds.), Readings in Therapy with Older People. Rockville, Maryland: NIMH, U.S. Department of HEW, No. (ADM 77-409).

Bhutani, G. E. (1995/1996). Survey for PSIGE training task group. PSIGE Newsletter, 55, December/January, 23-24.

Biggs, S. (1993). Understanding Ageing: Images, Attitudes and Professional Practice. Buckingham, Philadelphia: Open University Press.

Biggs, S. (1989). Professional helpers and resistances to work with older people. Ageing and Society, 9, 43-60.

Blum, J. E. & Tallmer, M. (1977). The therapist vis-à-vis the older patient. Psychotherapy: Theory, Research and Practice, 14, 361-367.

Bowling, A. (1990). The prevalence of psychiatric morbidity among people aged 85 and over living at home: Associations with reported somatic symptoms and with consulting behaviour. Social Psychiatry and Psychiatric Epidemiology, 25, 132-140.

British Psychological Society (1995). Purchasing Clinical Psychology Services: Services for Older People, their Families and Other Carers. Briefing paper No. 5, Divisions of Clinical Psychology: British Psychological Society.

Britton, P. G. (1999). Training: Reflections and opportunities. PSIGE Newsletter, 68, April, 3-5.

Britton, P. G. & Woods, R. T. (1996). Introduction. In Woods, R. T. (Ed.) Handbook of the Clinical Psychology of Ageing. John Wiley & Sons: Chichester.

Brown, R. (1986). Social Psychology. London: Free Press.

Busse, E. (1987). Innovations in psychogeriatrics: Interdisciplinary research. In M. Bergener (Ed.) Psychogeriatrics: An International Handbook. New York: Springer.

Busse, E. W. & Blazer, D. G. (1980). Handbook of Geriatric Psychiatry. New York: Van Norstand Reinhold.

Butler, A. (1990). A re-evaluation of social work students' career interests. Journal of Social Work Education, 26, 1, 45-56.

Butler, R. N. (1985). Geriatric psychiatry. In H. I. Kaplan & J. B. Saddock (eds.), Comprehensive Textbook of Psychiatry. Baltimore: Williams & Wilkins.

Butler, R. N. (1980). Ageism: A foreword. Journal of Social Issues, 36, 8-11.

Butler, R. N. (1963). The life review: An interpretation of reminiscence in the aged. Psychiatry, 26, 65-76.

Butler, R. N. (1968). Towards a psychiatry of the life cycle. Psychiatric Research Reports, 23, 233-248.

Butler, R. N. (1975). Why Survive Being Old in America? New York: Harper Row.

Butler, R. N. (1975). Psychiatry and the elderly: An overview. American Journal of Psychiatry, 132, 893-900.

Butler, R. N. & Lewis, M. I. (1977). Aging and mental health. St Louis: C.V. Mosby.

Bytheway, B. (1990). Age. In S. M. Peace (Ed.) Researching Social Gerontology. London: Sage.

Cath, S. (1972). Psychoanalytic viewpoints on aging - An historical survey. In D. Kent, R. Kastenbaum & S. Sherwood (eds.) Research Planning and Action for the Elderly. New York: Behavioural Publications.

Clark-Carter, D. (1997). Doing Quantitative Psychological Research: From Design to Report. Psychology Press, Taylor & Francis: Hove, East Sussex.

Cohen, G. D. (1977). Mental health services and the elderly: Needs and options. In S. Steury and M. L. Blank (Eds.) Readings in Therapy with Older People. Rockville, Maryland: NIMH, US Department of HEW, No. (ADM) 77-409).

Cohen, J. (1988). Statistical Power Analysis for the Behavioural Sciences. Hillsdale, New Jersey: Lawrence Erlbaum Associates.

Collette-Pratt, C. (1976). Attitudinal predictors of devaluation of old age in a multigenerational sample. Journal of Gerontology, 31, 193-197.

Compton, B. R. (1989). Psychological aspects of ageing in residential care. Adult Residential Care Journal, 3, 221-230.

Conte, H. R., Weiner, M. B. & Plutchik, R. (1982). Measuring death anxiety: Conceptual, psychometric and factor analytic aspects. Journal of Personality and Social Psychology, 43, 775-785.

Crockett, W. H. & Hummert, M. L. (1987). Perceptions of aging and the elderly. In K. W. Schaie & C. Eisdorfer (Eds.) Annual Review of Gerontology and Geriatrics (Vol. 7). New York: Springer Publications.

Cuthbertson, G. (1999). Factors affecting recruitment and retention of clinical psychologists. Clinical Psychology Forum, 124, February, 19-23.

Cyrus-Lutz, C. & Gaitz, C. M. (1972). Psychiatrists' attitudes towards the aged and aging. The Gerontologist, 12, 163-167.

Dattel, A. R. & Neimeyer, R. A. (1990). Sex differences in death anxiety: Testing the emotional expressiveness hypothesis Death Studies, 14, 1-11.

De Beauvoir, S. (1977). Old Age. London: Penguin

Dellasega, C & Curriero, F. C. (1991). The effects of institutional and community experiences on nursing students' intentions toward work with the elderly. Journal of Nursing Education, 30, 9, 405-410.

DePaola, S. J., Neimeyer, R. A., Lupfer, M. B. & Fielder, J. (1992). Death Concern and attitudes toward the elderly in nursing home personnel. Death Studies, 16, 537-555.

DePaola, S. J., Neimeyer, R. A. & Ross, S. K. (1994). Death concerns and attitudes toward the elderly in nursing home personnel as a function of their training. Omega, 29, 3, 231-248.

Department of Health (1994). Cited in A. D. Roth & P. Fonagy (Eds.) What Works for Whom? A critical review of psychotherapy research. New York: Guildford Press.

Devins, G. M. (1979). Death anxiety and voluntary passive euthanasia. Journal of Consulting and Clinical Psychology, 47, 301-309.

Dick, I. H., Gallagher-Thompson, D. & Thompson, L. W. (1996). Cognitive-behavioural therapy. In Woods, R. T. (Ed.) Handbook of the Clinical Psychology of Ageing. John Wiley & Sons: Chichester.

Dixon, J. & Gregory, L. (1987). Ageism. Action Baseline, Winter, 21-23.

Dye, C. J. (1978). Psychologists' role in the provision of mental health care for the elderly. Professional Psychology, February, 38-49.

Eakes, G. G. (1985). The relationship between death anxiety and attitudes towards the elderly among nursing staff. Death Studies, 9, 163-172.

Edinberg, M. A. (1985). Mental Health Practice with the Elderly. Engelwood Cliffs, NJ: Prentice-Hall.

Erikson, E. H. (1982). The Life Cycle Completed: A Review. New York: Norton.

Erikson, E. H., Erikson, J. M. & Kivnick, H. Q. (1986). Vital Involvement in Old Age. New York: Norton.

Eweka, I. (1994). Counselling for old and elderly people: Time for positive action. Counselling, 5, 4, 296-298.

Feifel, H. (1959). The Meaning of Death. New York: McGraw-Hill.

Feifel, H., Hanson, S., Jones, R. & Edwards, L. (1967). Physicians consider death. In Proceedings 75th Annual Convention. American Psychological Association, Washington DC: American Psychological Association.

Firestone, R. W. (1994). Psychological defenses against death anxiety. In R. A. Neimeyer (Ed.) Death Anxiety Handbook: Research, Instrumentation and Application. Washington, DC: Taylor & Francis.

Ford, C. & Sbordone, R. (1980). Attitudes of psychiatrists towards elderly patients. American Journal of Psychiatry, 137, 5, 571-575.

Freud, S. (1953). On Psychotherapy. In J. Strachey (Trans.), The Complete Works of Sigmund Freud (Vol. 6, p. 249-263). London: Hogarth (Original work published 1905).

Furnish, S. (1994). The psychological needs of older people as recipients of health care services. Clinical Psychology Forum, 71, September, 2-8.

Gardner, D. L. & Perritt, L. J. (1983). Attitude changes toward the elderly: A national staff development program report. Physical and Occupational Therapy in Geriatrics, 2, 17-30.

Garland, J., Lewis, J. & Pimm, J. (1989). We have normality: Increasing the probability of recruitment for work with older people. Clinical Psychology Forum, 19, 9-12.

Garrard, J., Rolnick, S. J., Nitz, N. M., Leupke, L., Jackson, J., Fischer, L. R., Leibson, C., Bland, P. C., Heinrich, R. & Waller, L. A. (1998). Clinical detection of depression among community-based elderly people with self-reported symptoms of depression. Journals of Gerontology Series A - Biological Sciences and Medical Sciences, 53, m92-m101.

Gatz, M. & Pearson, C. G. (1988). Ageism revised and the provision of psychological services. American Psychologist, 43, 3, 184-188.

Giles, H. & Coupland, N. (1991). Language: Contexts and Consequences. Milton Keynes: Open University Press.

Gilleard, C., Askham, J., Biggs, S., Gibson, H. B. & Woods, B. (1995). Psychology, ageism and health care: A DCP symposium. Clinical Psychology Forum, 58, November, 14-15.

Goudie, F. & Richards, G. (1993). The psychological needs of older adults and their carers in primary care settings. Unpublished report, Community Health, Sheffield, April.

Government Statistical Service (1999). The source of UK facts and figures. www.statistics.gov.uk/stats/ukinfigs/pop.htm

Gray, I. (1997). A follow up survey of clinical psychology training resources carried out by the Group of Trainers in Clinical Psychology. Clinical Psychology Forum, 108, 36-40.

Green, S. K. (1981). Attitudes and perceptions about the elderly: Current future perspectives. International Journal of Aging and Human Development, 13, 99-119.

Greene, R. (1983). Ageism, death anxiety and the caseworker. Journal of Social Service Research, 7, 1, Fall.

Greene, R. R. (1986). Countertransference issues in social work with the aged. Journal of Gerontological Social Work, 9, 3, 79-89.

Gurland, B. J. & Cross, P. S. (1982). Epidemiology of psychopathology in old age. Psychiatric Clinics of North America, 5, 11-26.

Guttman, D. (1982). Training in the clinical psychology of aging: Observations and recommendations. In J. Santos & G. R. VandenBos (Eds.) Psychology and the Older Adult: Challenges for training in the 1980s. Washington, DC: American Psychological Association.

Haight, B. K., Christ, M. A. & Dias, J. K. (1994). Does nursing education promote ageism? Journal of Advanced Nursing, 20, 382-390.

Hall, J., Koch, H., Pilling, S. & Winter, K. (1986). Health services information and clinical psychology. Bulletin of the British Psychological Society, 39, 126-130.

Harper, D. J., Manasse, P. R. & Newton, J. T. (1992). Nurses' attitudes and satisfaction in two psychogeriatric wards: Their structure and correlates. Journal of Advanced Nursing, 17, 676-681.

Hildebrand, H. P. (1982). Psychotherapy with older patients. British Journal of Medical Psychology, 55, 19-28.

Hildebrand, P. (1986). Dynamic psychotherapy with the elderly. In I. Hanley & M. Gilhooly (Eds.) Psychological Therapies for the Elderly. London: Croom Helm.

Hintze, J., Templer, D. I., Cappelletty, G. C. & Fredrick, W. (1994). Death depression and death anxiety in HIV-infected males. In R. A. Neimeyer (Ed.) Death Anxiety Handbook: Research, Instrumentation and Application. Washington, DC: Taylor & Francis.

Hinze, E. (1987). Transference and countertransference in the psychoanalytic treatment of older patients. International Review of Psychoanalysis, 14, 465-474.

Hoelter, J. W. (1979). Multidimensional treatment of fear of death. Journal of Consulting and Clinical Psychology, 47, 5, 996-999.

Holcomb, L. E. Neimeyer, R. A. & Moore, M. K. (1993). Personal meanings of death: A content analysis of free response narratives. Death Studies, 17, 299-318.

Howell, D. C. (1992). Statistical Methods for Psychology. Boston, MA: PWS Publishers.

Howells, E. (1992). Is a separate psychological service for older people necessary? Clinical Psychology Forum, April, 2-5.

Howley, L. (1999). Influence on choice of specialism: Trainee psychologists, self esteem, identity and experience. PSIGE Newsletter, 68, April, 9-13.

Ingstad, P. & Götestam, K. (1987). Staff attitude changes after environmental changes on a ward for psychogeriatric patients. International Journal of Social Psychology, 33, 237-244.

James, J. W. & Haley, W. E. (1995). Age and health bias in practising clinical psychologists. Psychological Aging, 10, 610-616.

Jones, F. (1999). Talking ageing and ageing talk. The Psychologist, 12, 7, 336.

Jung, C. G. (1964). Man and His Symbols. London: Aldus Books.

Kafer, R. A., Rakowski, W., Lachman, M. & Hickey, T. (1980). Aging Opinion Survey: A report on instrument development. International Journal of Aging and Human Development, 11, 319-333.

Kastenbaum, L. (1963). The reluctant therapist. Geriatrics, 19, 296-301.

Kastenbaum, R. (1978). Personality theory, therapeutic approaches and the elderly client. In M. Storandt, I. C. Siegler & M. F. Elias (Eds.) The Clinical Psychology of Aging. New York: Plenum.

Kastenbaum, R. & Costa, P. T. (1977). Psychological perspectives on death. Annual Review of Psychology, 28, 22-249.

Kat, B. (1995). Why such a woeful shortage of trained clinical psychologists? Health Service Journal, September.

Kay, D. W. K. & Bergmann, K. (1980). Epidemiology of mental disorders among the aged in the community. In J. E. Birren & R. B. Sloane (Eds.) Handbook of Mental Health and Aging. Englewood Cliffs, New Jersey: Prentice-Hall.

Kline, P. (1993). The Handbook of Psychological Testing. London: Routledge.

Knight, B. (1985-86). Therapists' attitudes as explanation of underservice of elderly in mental health: Testing an old hypothesis. International Journal of Aging and Human Development, 22, 4, 261-269.

Knight, B. (1996). Psychotherapy with Older Adults. London: Sage Publications.

Knight, B. (1996b) Psychodynamic therapy with older adults: Lessons from scientific gerontology. In Woods, R. T. (Ed.) Handbook of the Clinical Psychology of Ageing. John Wiley & Sons: Chichester.

Knox, V. J., Gekoski, W. L. & Johnosn, E. A. (1986). Contact with and perceptions of the elderly. The Gerontologist, 26, 3, 309-313.

Krippendorff, K. (1980). Content Analysis: An Introduction to its Methodology. London: Sage Publications.

Kubler-Ross, E. (1971). What is it like to be dying? American Journal of Nursing, 71, 1, 54-61.

Kucharski, L. T., White, R. M. & Schratz, M. (1979). Age bias, referral for psychological assistance and the private physician. Journal of Gerontology, 34, 3, 423-428.

Larner, S. (1986). Training issues in working with the elderly. PSIGE Newsletter, 20, 405.

Lasher, K. P. & Faulkeder, P. J. (1993). Measurement of aging anxiety: Development of the anxiety about aging scale. International Journal of Aging and Human Development, 34, 4, 247-259.

Lavender, A. (1993). Factors determining trainees' choice of job. Clinical Psychology Forum, 60, October, 26-30.

Lester, D., Getty, C. & Kneisl, C. R. (1974). Attitudes of nursing students and nursing faculty toward death. Nursing Research, January - February, 23, 1, 50-53.

Lewis, M. I. & Butler, R. N. (1974). Life review therapy. Geriatrics, 29, 165-173.

Litwin, H. (1994). The professional standing of work with the elderly persons among social work trainees. British Journal of Social Work, 24, 53-69.

Livingston, P. B. & Zimet, C. N. (1965). Death anxiety, authoritarianism and choice of specialty in medical students. The Journal of Nervous and Mental Disease, 140, 3, 222, 229.

Lonetto, R., Mercer, G. W., Fleming, S., Bunting, B. & Clare, M. (1980). Death anxiety among university students in Northern Ireland and Canada. Journal of Psychology, 104, 75-82.

Long, D. D. (1985-6). A cross-cultural examination of fears of death among Saudi Arabians. Omega, 16, 43-50

Loo, R. (1984). Personality correlates of the Fear of Death and Dying Scale. Journal of Clinical Psychology, 40, 120-122.

MPAG (1990). Clinical Psychology Project Full Report. London: Department of Health.

McAlpine, C. H., Gilhooly, M. L. M., Murray, K., Lennox, I. M. & Caird, F. I. (1995). Medical students and geriatric medicine. Special Issue: The humanities and medical education. Academic Medicine, 70, 749-750.

MacDonald (1986) Cited in A. D. Roth & P. Fonagy (Eds.) What Works for Whom? A critical review of psychotherapy research. New York: Guildford Press.

McTavish, D. G. (1971). Perceptions of old people: A review of research methodologies and findings. The Gerontologist, 11, 90-101.

Maheux, B., Legault, C. & Lambert, J. (1989) Increasing response rates in physicians mail surveys: An experimental study. American Journal of Public Health, 79, 638-639.

Manpower Advisory Service (1989). The Manpower Advisory Service Review of Clinical Psychology Services in the NHS. Cheltenham: MAS.

Manthorpe, J. (1994). Reading around: Dementia and ethnicity. Journal of Dementia Care, Sept/Oct, 22-23.

Marmor, J. (1975). Psychiatrists and their patients: A national study of private office practice. Washington, DC: American Psychiatric Association.

Martin, L. M., Fleming, K. C. & Evans, J. M. (1995). Recognition and management of anxiety and depression in elderly patients. Mayo Clinic Proceedings, 70, 999-1006.

Martindale, B. (1989). Becoming dependent again: The fears of some elderly persons and their younger therapists. Psychoanalytic Psychotherapy, 4, 1, 67-75.

Meerlo, J. A. M. (1955). Transference and resistance in geriatric psychotherapy. Psychoanalytic Review, 42, 72-82.

Meerloo, J. A. M. (1955b). Psychotherapy with elderly people. Geriatrics, 10, 583-587.

Menzies-Lyth, I. (1988). Thoughts on the maternal role in contemporary society. In Containing Anxiety in Institutions: Selected essays. London: Free Association Books.

Miles, H. B. & Huberman, A. M. (1994). Qualitative Data Analysis. California: Sage Publishers.

Mount, J. (1993). Effect of a practicuum of well elderly on physical therapy students' attitudes towards older people and their intention to work with the elderly. Gerontology and Geriatrics Education, 13, 13-24.

Mutschler, P. (1971). Factors affecting choice of perseveration in social work with the aged. Gerontologist, 11, 231-241.

Neimeyer, R. A. (1995). Death Anxiety. In H. Wass, F. Berardo & R. A. Neimeyer (Eds.) Dying: Facing the facts. New York: Hemisphere.

Neimeyer, R. A. & Moore, M. K. (1994). In R. A. Neimeyer (Ed.) Death Anxiety Handbook: Research, Instrumentation and Application. London: Taylor & Francis.

Neimeyer, R. A. & Moore, M. K. (1989). Assessing personal meanings of death: Empirical refinements in the Threat Index. Death Studies, 13, 227-240.

Nelson, L. D. & Nelson, C. C. (1975). A factor analytic inquiry into the multidimensionality of death anxiety. Omega, 6, 2, 171-178.

Nemiroff, R. A. & Colarusso, C. A. (1985). The Race Against Time: Psychotherapy and Psychoanalysis in the Second Half of Life. New York: Plenum Press.

O'Connor et al. (1988). Cited in A. D. Roth & P. Fonagy (Eds.) What Works for Whom? A critical review of psychotherapy research. New York: Guildford Press.

O'Leary, E. (1995). Counselling Older Adults: Perspectives, Approaches and Research. London: Chapman & Hall.

Oberleder, M. (1966). Psychotherapy with the aging: An art of the possible? Psychotherapy: Theory, Research and Practice, 3, 139-142.

Oppenheim, A. N. (1992). Questionnaire Design, Interviewing and Attitude Measurement. New Edition. London: Pinter.

Orbach, A. (1996). Not Too Late: Psychotherapy and Ageing. London: Jessica Kingsley Publishers.

Palmore, E. (1977). Facts on aging: A short quiz. The Gerontologist, 17, 315-320.

Peterson, C. C., Hall, L. C. & Peterson, J. L. (1988). Age, sex and contact with elderly adults as predictors of knowledge about psychological ageing. International Journal of Aging and Human Development, 26, 2, 129-137.

Poggi, R. G. & Berland, D. I. (1985). The therapists' reactions to the elderly. The Gerontologist, 25, 508-513.

Powell, G. E. (1989). Selecting and developing measures. In G. Parry & F. N. Watts (Eds.) Behavioural and Mental Health Research: A Handbook of Skills and Methods. Hove: Lawrence Erlbaum Associates.

Rabins, P. V. (1996). Barriers to diagnosis and treatment of depression in elderly patients. American Journal of Geriatric Psychiatry, 4, S1, s79-s83.

Ray, D. C., McKinney, K. A. & Ford, C. V. (1987). Differences in Psychologists' Ratings of Older and Younger Clients. The Gerontologist, 27, 1, 82-86.

Ray, D. C., Raciti, M. A. & Ford, C. V. (1985). Ageism in psychiatrists: Associations with gender, certification and theoretical orientation. The Gerontologist, 25, 496-500.

Rechtschaffen, A. (1959). Psychotherapy with geriatric patients: A review of the literature. Journal of Gerontology, 14, 73-84.

Robson, C. (1993). Real World Research: A Resource for Social Scientists and Practitioner-researchers. Oxford: Blackwell.

Rosencranz, H. A. & McNevin, T. E. (1969). A factor analysis of attitudes towards the aged. The Gerontologist, 9, 55-59.

Roybal, E. R. (1988). Mental health and ageing: The need for an expanded federal response. American Psychologist, March, 43, 3, 189-194.

Rust, J. & Golombok, S. (1989). Modern Psychometrics: The Science of Psychological Assessment. London: Routledge.

Saarela, T. & Vikuari, M. (1995). Attitudes of health care professionals towards care of the elderly. International Journal of Geriatric Psychiatry, 10, 797-800.

Salmon, P. (1996). The importance of positioning. Changes, 14, 3, 218-222.

Salter, C. A. & Salter, C. (1976). Attitudes toward ageing and behaviours towards the elderly among young people as a function of death anxiety. The Gerontologist, 16, 232-236.

Santos, J. F. & VandenBos, G. R. (1982) Psychology and the Older Adult: Challenges for Training in the 1980s. Washington, DC: American Psychological Association.

Schaie, K. W. (1993). Ageist language in psychological research. American Psychologist, 48, 1, 49-51.

Scher, M. (1981). Men in hiding: A challenge for the counsellor. Personnel and Guidance Journal, 60, 199-202.

Schonfield, D. (1982). Who is stereotyping whom and why? The Gerontologist, 22, 267-272.

Scogin, F. & McElreath, L. (1994). Efficacy of psychosocial treatment for depression: A quantitative review. Journal of Consulting and Clinical Psychology, 62, 69-74.

Scott, A. & Bhutani, G. (1999). Career choices and attitudes to the Older Adult specialty, Clinical Psychology Forum, 126, April, 11-15.

Scott, A. (1997). Trainee Clinical Psychologists' career choices and attitudes to older adult specialty: Results of a national survey. Unpublished report. Lancashire Clinical Psychology Training Course.

Settin, M. (1982). Clinical judgement in geropsychology practice. Psychotherapy: Theory, Research and Practice, 19, 397-404.

Shura, S. (1974). Aging: An Album of People Growing Old. New York: Wiley.

Slater, R. (1995). The Psychology of Growing Old: Looking Forward. Buckingham, Philidelphia: Open University Press.

Smotkin, D., Eyal, N. & Lomranz, J. (1992). Motivations and attitudes of clinical psychologists regarding treatment of the elderly. Educational Gerontology, 18, 177-192.

Sobel, E. (1980). Countertransference issues with the later life patient. Contemporary Psychoanalysis, 16, 2, 211-222.

Soyer, D. (1969). Reverie on working with the aged. Social Casework, 50, 5, 291-294.

Sparacino, J. (1978). Individual psychotherapy with the aged: A selective review. International Journal of Aging and Human Development, 9, 3, 976-983.

Sprung, G. M. (1989). Transferential issues in working with older adults. Social Casework: The Journal of Contemporary Social Work, 597-602.

Stern, K., Smith. J. & Frank, M. (1953). Mechanisms of transference and countertransference in psychotherapeutic and social work with the aged. Journal of Gerontology, 8, 328.

Templer, D. I. (1970). The construction and validation of a Death Anxiety Scale. Journal of General Psychology, 82, 165-177.

Thomas, C. & Cook, F. (1995). An investigation into the factors determining the choice of specialism in clinical psychology. Clinical Psychology Forum, 78, 13-17.

Thompson, L. W., Gallagher, D. & Breckenridge, J. S. (1987). Comparative effectiveness of psychotherapies for depressed elders. Journal of Consulting and Clinical Psychology, 55, 385-390.

Tobacyk, J. & Eckstein, D. (1980). Death threat and death concerns in the college student. Omega, 11, 139-155.

Tomer, A. (1992). Death anxiety in adult life - theoretical perspectives. Death Studies, 16, 475-506.

Treharne, G. (1990). Attitudes towards the care of elderly people. Are they getting better? Journal of Advanced Nursing, 15, 777-781.

Tuckman, J. & Lorge, I. (1953). Attitudes toward old people. Journal of Social Psychology, 37, 249-260.

Turpin, G. (1995). A survey of clinical placements and supervisors involved in clinical psychology postgraduate training. Clinical Psychology Forum, 86, 36-40.

Urquhart Law, G., McCarron, L. A. & Wright, C. (1999). Trainee forum: What do trainees want in their first job after qualification? Clinical Psychology Forum, 123, January, 56.

VandenBos, G. R., Strapp, J. & Kilburg, R. R. (1981). Health service providers in psychology. American Psychologist, 36, 1395-1418.

Vickio, C. J. & Cavanaugh, J. C. (1985). Relationship among death anxiety, attitudes towards ageing and experience with death in nursing home employees. Journal of Gerontology, 40, 3, 347-349.

Victor, C. R. (1994). Old Age in Modern Society: A Textbook of Social Gerontology. Chapman & Hall: London.

Walkey, F. H. (1982). The Multidimensional Fear of Death Scale: An independent analysis. Journal of Consulting and Clinical Psychology, 50, 466-467.

Warren, W. G. & Chopra, P. N. (1978). Some reliability and validity considerations on Austrian data for the Death Anxiety Scale. Omega, 9, 293-240.

Wass, H., Corr, C. A., Pacholski, R. A. & Forfar, C. S. (1985). Death Education II: An Annotated Resource Guide. Washington, DC: Hemisphere.

Weinstein, S. E. (1978). Senior medical student attitudes towards death and dying. Unpublished Doctoral dissertation, University of Maryland.

West, H. L. & Levy, W. J. (1985). Knowledge of ageing in the medical profession. Gerontology and Geriatrics Education, 4, 97-105.

Wilson, J. F. & Hafferty, F. W. (1983). Long-term effects of a seminar on aging and health for first-year medical students. The Gerontologist, 23, 319-324.

Wolk, R. L. & Wolk, R. B. (1971). Professional workers' attitudes toward the aged. Journal of the American Geriatrics Society, 19, 624.

Woods, R. & Roth, A. (1996). Effectiveness of psychological interventions with older people. In A. D. Roth & P. Fonagy (Eds.) What Works for Whom? A critical review of psychotherapy research. New York: Guildford Press.

Woolfe, R. & Biggs, S. (1997). Counselling older adults: issues and awareness. Counselling Psychology Quarterly, 10, 189-194.

Yalom, I. D. (1980). Existential Psychotherapy. New York: Basic Books.

Yesavage, J. A. & Karasu, T. B. (1982) Psychotherapy with elderly patients. American Journal of Psychotherapy, 36, 1, January, 41-55.

Zarit, S. H. & Knight, B. G. (1996). A Guide to Psychotherapy and Aging: Effective Clinical Interventions in a Life-stage context. Washington, DC: American Psychological Association.

Appendices

Appendix One:	Questionnaire (first draft prior to piloting)
Appendix Two:	Letter to course directors including consent form
Appendix Three:	Covering letter sent to trainees
Appendix Four:	Self de-briefing form
Appendix Five:	Non-participation form
Appendix Six:	Request for summary of results form
Appendix Seven:	Summary of the reasons for non-participation
Appendix Eight:	Pilot information form given to trainees piloting questionnaire
Appendix Nine:	Questionnaire (final draft after piloting)
Appendix Ten:	Ethical Approval from South Thames (Salomons) Clinical Psychology Training Scheme
Appendix Eleven:	Coding frames with examples
Appendix Twelve:	Distributions and data transformations for variables entered into multiple regression
Appendix Thirteen:	Correlations between variables entered into multiple regressions

Investigating barriers and motivations to working with older people among Psychologists in Clinical Training in the UK

---

1. Age: _____ 2. Sex: M F

3. Ethnic origin: _____ 4. Current year of training: 1st 2nd 3rd

5. On qualification I want to work in:

	Not at all					*Very Much*
Child and Adolescent services	1	2	3	4	5	6
Adult Mental Health	1	2	3	4	5	6
Rehab. and Continuing Care	1	2	3	4	5	6
Services for people with learning disabilities	1	2	3	4	5	6
Services for older people (over 65)	1	2	3	4	5	6
Forensic services	1	2	3	4	5	6
Health psychology services	1	2	3	4	5	6
Neuropsychology services	1	2	3	4	5	6
Primary Care Services	1	2	3	4	5	6
Other, please specify_____	1	2	3	4	5	6

6. What factors have influenced your decision to work with this age group?

_____

_____

_____

_____

Pre-training experience

7. I have some experience of working in services for older people prior to clinical psychology training

Yes *No*

a) In what capacity (e.g. Assistant Psychologist, Care Assistant etc.)? _____

b) For approximately how long (years, months)? _____

8. Before clinical psychology training how much did you want to work with older people?

Not at all					*Very much*
1	2	3	4	5	6

please continue overleaf

Experience during training

9. During my clinical psychology training (please tick either a, b, c or d):

a) I have had/I am currenbtly on a placement with a supervisor, working specifically in a service for older people ❑

b) I have gained my core experience with older people across a number of placements ❑

If yes, how many? _____

c) I have not yet had any experience of working witholder people ❑

If you have not worked with older people during clinical psychology training please move on to question 15.

10. Has your experience of working with older people during clinical psychology training made you feel more or less likely to work in services for older people?

Less likely						*More likely*
1	2	3	4	5	6	7

11. How would you rate the quality of your placement with older people?

Very Poor						*Very Good*
1	2	3	4	5	6	7

12. How would you rate the quality of your supervision during your placement with older people?

Very Poor						*Very Good*
1	2	3	4	5	6	7

13. What was the most emotionally rewarding aspect of working with older clients?

_____

_____

_____

_____

_____

14. What was the most emotionally challenging aspect of working with older clients?

_____

_____

_____

_____

_____

please continue overleaf

Psychotherapy with older people

15. In psychotherapy, is it necessary to respond differently and with a modified approach to older clients?

Yes ***No***

If yes, what particular factors would you take into account when working with older clients?

16. Working with older people provides the opportunity to apply psychological knowledge and skills?

Not at all						*A great degree*
1	2	3	4	5	6	7

Recruitment

17. Why do you think it may be difficult to recruit clinical psychologists to work with older people?

18. How do you think recruitment to this specialty can be improved?

please continue overleaf

Multidimensional Fear of Death Scale

Listed below are death-related events and circumstances that some people find to be fear-evoking. Indicate the extent to which you agree or disagree with each statement by circling <u>one</u> number for each item. Do <u>not</u> skip any items if you can avoid it.

1 = Strongly disagree
2 = Mildly disagree
3 = Neither agree nor disagree
4 = Mildly agree
5 = Strongly agree

1. I am afraid of dying very slowly	1	2	3	4	5
2. I dread visiting a funeral home	1	2	3	4	5
3. I would like to donate my body to science	1	2	3	4	5
4. I have a fear of people in my family dying	1	2	3	4	5
5. I am afraid that there is no afterlife	1	2	3	4	5
6. There are probably many people pronounced dead that are really still alive	1	2	3	4	5
7. I am afraid of my body being disfigured when I die	1	2	3	4	5
8. I have a fear of not accomplishing my goals in life before dying	1	2	3	4	5
9. I am afraid of meeting my creator	1	2	3	4	5
10. I am afraid of being buried alive	1	2	3	4	5
11. I dread the thought of my body being embalmed some day	1	2	3	4	5
12. I am afraid I will not live long enough to enjoy my retirement	1	2	3	4	5
13. I am afraid of dying in a fire	1	2	3	4	5
14. Touching a corpse would not bother me	1	2	3	4	5
15. I do not want medical students using my body for practice after I die	1	2	3	4	5
16. If people I am very close to were to die suddenly, I would suffer for a long time	1	2	3	4	5
17. If I were to die tomorrow, my family would be upset for a long time	1	2	3	4	5
18. I am afraid that death is the end of one's existence	1	2	3	4	5
19. People should have autopsies to ensure that they are dead	1	2	3	4	5
20. The thought of my body being found after I die scares me	1	2	3	4	5
21. I am afraid I will not have time to experience everything I want to do	1	2	3	4	5

please continue overleaf

Multidimensional Fear of Death Scale (continued)

1 = Strongly disagree
2 = Mildly disagree
3 = Neither agree nor disagree
4 = Mildly agree
5 = Strongly agree

22. I am afraid of experiencing a great deal of pain when I die	1	2	3	4	5
23. Discovering a dead body would be a horrifying experience	1	2	3	4	5
24. I do not like the thought of being cremated	1	2	3	4	5
25. Since everyone dies, I won't be too upset when my friends die	1	2	3	4	5
26. I would be afraid to walk through a graveyard, alone at night	1	2	3	4	5
27. I am afraid of dying of cancer	1	2	3	4	5
28. It doesn't matter whether I am buried in a wooden box or a steel vault	1	2	3	4	5
29. It scares me to think I may be conscious while lying in a morgue	1	2	3	4	5
30. I am afraid to think there may not be a Supreme Being	1	2	3	4	5
31. I have a fear of suffocating (including drowning)	1	2	3	4	5
32. It would be bother me to remove a dead animal from the road	1	2	3	4	5
33. I do not want to donate my eyes after I die	1	2	3	4	5
34. Sometimes I get upset when acquaintances die	1	2	3	4	5
35. The thought of being locked in a coffin after I die scares me	1	2	3	4	5
36. No one can say for sure what will happen after death	1	2	3	4	5
37. If I die, my friends would be upset for a long time	1	2	3	4	5
38. I hope more than one doctor examines me before I am pronounced dead	1	2	3	4	5
39. I am afraid of things which have died	1	2	3	4	5
40. The thought of my body decaying after I die scares me	1	2	3	4	5
41. I am afraid I may never see my children grow up	1	2	3	4	5
42. I have a fear of dying violently	1	2	3	4	5

please continue overleaf

Anxiety About Aging Scale

Please indicate the extent to which you agree or disagree with each of the following statements by circling the appropriate number following each item based on the rating scale provided below.

1 = Strongly disagree
2 = Mildly disagree
3 = Neither agree nor disagree
4 = Mildly agree
5 = Strongly agree

1. I enjoy being around old people	1	2	3	4	5
2. I fear that when I am old all my friends will be gone	1	2	3	4	5
3. I like to visit my older relatives	1	2	3	4	5
4. I have never lied about my age in order to appear younger	1	2	3	4	5
5. I fear it will be very hard for me to find contentment in old age	1	2	3	4	5
6. The older I become, the more I worry about my health	1	2	3	4	5
7. I will have plenty to occupy my time when I am old	1	2	3	4	5
8. I get nervous when I think about someone else making decisions for me when I am old	1	2	3	4	5
9. It doesn't bother me at all to imagine myself as being old	1	2	3	4	5
10. I enjoy talking with old people	1	2	3	4	5
11. I expect to feel good about life when I am old	1	2	3	4	5
12. I have never dreaded the day I would look in the mirror and see grey hairs	1	2	3	4	5
13. I feel very comfortable when I am around an old person	1	2	3	4	5
14. I worry that people will ignore me when I am old	1	2	3	4	5
15. I have never dreaded looking old	1	2	3	4	5
16. I believe that I will still be able to do most things for myself when I am old	1	2	3	4	5
17. I am afraid that there will be no meaning in life when I am old	1	2	3	4	5
18. I expect to feel good about myself when I am old	1	2	3	4	5
19. I enjoy doing things for old people	1	2	3	4	5
20. When I look in the mirror, it bothers me to see how my looks have changed with age	1	2	3	4	5

please continue overleaf

APPENDIX ONE

Aging Opinion Survey

The statements you are going to read are opinions. Anyone could agree with some of them and object to others. The question is which are the opinions with which *you* agree or disagree. Please indicate your judgement about each idea expressed by circling a number between 1 and 9. The low number 1, 2, 3 and 4 mean some degree of disagreement and the high numbers 6, 7, 8 and 9 mean some degree of agreement. Five then means you have no opinion one way or the other. Only circle one number between 1 and 9 for each sentence. Do not stop to think too long about the statements, all that is wanted is your first reaction.

DISAGREE							*AGREE*	
Strongly			*a little*		*a little*			*Strongly*
1	2	3	4	5	6	7	8	9

1. Community organisations would function more smoothly if older persons were included on their governing boards 1 2 3 4 5 6 7 8 9

2. The older my friends get the less respect they have for the privacy of others
1 2 3 4 5 6 7 8 9

3. Old people usually interfere with their adult children's child-rearing practices
1 2 3 4 5 6 7 8 9

4. I would prefer to always live in an area where people my age predominate
1 2 3 4 5 6 7 8 9

5. I would always want to live in a neighbourhood where there was a variety of age groups
1 2 3 4 5 6 7 8 9

6. After retirement one should not have much influence in public policy making
1 2 3 4 5 6 7 8 9

7. Most people I know feel that the elderly deserve a great deal of admiration
1 2 3 4 5 6 7 8 9

8. The elderly have a wealth of knowledge and experience that is not sufficiently utilised
1 2 3 4 5 6 7 8 9

9. Youthful enthusiasm and fresh ideas should count for more in today's world than the outdated notions of the older generation 1 2 3 4 5 6 7 8 9

10. The elderly are one of our great undeveloped natural resources
1 2 3 4 5 6 7 8 9

11. Older people are more or less a burden for the young
1 2 3 4 5 6 7 8 9

12. Society would benefit if the elderly had more say in government
1 2 3 4 5 6 7 8 9

13. Most elderly prefer to live in senior citizens apartment buildings
1 2 3 4 5 6 7 8 9

14. The elderly shouldn't be expected to do more for society after they retire
1 2 3 4 5 6 7 8 9

15. Neighbourhoods where the elderly predominate often become run down
1 2 3 4 5 6 7 8 9

please continue overleaf

Psychotherapy with the Elderly Questionnaire

The following is a list of phenomena that may appear in old age. Please check the phenomena that might hamper your psychotherapeutic work with older people (aged 65 and older).

Self-centredness	*Yes*	*No*	Decline in hearing	*Yes*	*No*
Apathy	*Yes*	*No*	Difficulties in memory	*Yes*	*No*
Decline in vision	*Yes*	*No*	Tendency to cry	*Yes*	*No*
Passivity	*Yes*	*No*	Dependence upon care-providers	*Yes*	*No*
Pessimism	*Yes*	*No*	Motor retardation	*Yes*	*No*
Physical malformation	*Yes*	*No*	Difficulty in learning new things	*Yes*	*No*
Decline in orientation	*Yes*	*No*	Impaired physical health	*Yes*	*No*
Mental rigidity	*Yes*	*No*	Neglect of appearance	*Yes*	*No*
Over-talkativeness	*Yes*	*No*	Difficulty in concentration	*Yes*	*No*
Stubbornness	*Yes*	*No*	Not psychologically minded	*Yes*	*No*
Intolerance	*Yes*	*No*	Slow reaction to stimuli	*Yes*	*No*
Suspiciousness	*Yes*	*No*	Difficulty changing habits	*Yes*	*No*
Over-emotionality	*Yes*	*No*	Pre-occupation with the past	*Yes*	*No*
Countertransference Issues	*Yes*	*No*	Please specify _____		

please continue overleaf

Are there any further comments you would like to make about working with older people and/or the process of completing this survey?

Thank you very much for taking the time to complete this questionnaire.

Please return in the envelope provided to:

Tina Lee
Psychologist in Clinical Training
South Thames (Salomons) Clinical Psychology Training Scheme
David Salomons Estate
Broomhill Road
Southborough
TUNBRIDGE WELLS
Kent, TN3 0TG

please continue overleaf

Dear

Study title: **INVESTIGATING MOTIVATIONS AND BARRIERS TO WORKING WITH OLDER PEOPLE AMONG PSYCHOLOGISTS IN CLINICAL TRAINING IN THE UK**

Salomons Ethics Committee have given me permission to contact you regarding the above research study. I hope that this project will prove to be important in a number of ways. Firstly it will explore how many clinical psychology trainees from current cohorts are interested in working with older people. Secondly it is hoped that it will represent a meaningful contribution to our understanding of what may influence clinical psychology trainees' decisions around working within this specialty. Lastly, it will explore the influence of completing a core placement in this specialty on motivation to work with this client group.

I am writing to you as a course director in the hope that you might be willing to involve your course in this work and to request your permission to distribute the measures to your trainees. The measures (which have been piloted on trainees at Salomons) include:

1. The Social Value of the Elderly Scale from the Aging Opinion Survey which will be used to assess attitudes towards older people.

2. The Multidimensional Fear of Death Scale which will be used to investigate death anxiety.

3. The Psychotherapy with the Elderly Questionnaire and a number of further questions devised by the researcher which will be used to determine trainees' attitude towards psychotherapy with older people.

4. Trainees will additionally be asked further information including their age, gender, ethnic origin, year of training and experience of working with older people.

Confidentiality and Consent

Should you allow me to approach your trainees, I would like to emphasise that all data will be treated in the strictest confidence and will be shredded once I have completed the dissertation in September 1999. Participation of individual trainees, even with your permission to proceed, is entirely voluntary. These points are clearly stated on the letter which I will be sending to each participant. In return for their support, each participant will also be given the opportunity to request a report on the

findings which will be sent to them on completion of the study. I can also send you a summary report of the results.

Debriefing

All those who participate will be asked to engage in self-debriefing and to contact myself or a member of the course staff at Salomons if they wish to discuss further any issues raised by completing the questionnaire.

Despite being aware that you, your course team and the trainees have strict demands on your time, I hope that this project will prove useful to your course in continuing to find ways to encourage trainees to work with older people. If it is convenient I would like to liaise with your admin. staff in distributing my questionnaires. Additionally, I should like to personalise the information packs in order to improve return rates and therefore request a list of the names of your trainees.

I do hope that you will be able to support me in my request. If you would like any additional information, please contact me at the above address, telephone number or by e-mail and I will be happy to answer any questions that you have. Should you wish your course to be involved, I would be grateful if you could return the enclosed reply form.

In the meantime, thank you for taking the time to read this information sheet.

Yours sincerely

Tina Lee, Psychologist in Clinical Training
South Thames (Salomons) Clinical Psychology Training Scheme
Supervised by Dr. Jane Volans, Consultant Clinical Psychologist, Oxleas NHS Trust

E-mail: tina.lee@lineone.net

Study title: Investigating motivations and barriers to working with older people among psychologists in clinical training

---

Please sign and return this form to confirm that you are happy for me to send my questionnaires to the trainees on your course.

Additionally it would be helpful if you could supply the name of a member of your secretarial or admin. staff with whom I could liaise and who could provide a list of names of trainees.

Name of admin. staff: .....

Signed: .....

Date: .....

Thank you for taking the time to read the enclosed letter and to reply to my request.

APPENDIX THREE

Please read this letter carefully before completing the enclosed survey

Dear

Your course director has kindly given me permission to approach you to take part in my research dissertation.

Aims

Previous research and anecdotal evidence has suggested that it may be difficult to recruit to psychology posts in older adult specialties. Through this research I intend to explore clinical psychology trainees' motivations and barriers to work with older people. Additionally I aim to explore issues which may effect trainees' decisions to work with older people, including death anxiety, fear of personal ageing, attitudes to older people, attitudes to psychotherapy with older clients, and experiences of working with older people both before and during training .

Whilst I do appreciate your time is precious, I hope that you may be interested in participating so that your views and experiences can be included. The opinions of trainees are essential when considering recruitment and your participation will go some way to establishing a truly representative sample. In return for your support, if you complete the enclosed form I can send you a summary of my findings.

Debriefing

The nature of this research, for example its focus on anxieties about ageing and death, may raise some personal issues. If for whatever reasons you feel that exploring these issues may be distressing in any way, for example if you have recently been bereaved or if someone close to you is seriously ill, may I suggest that you do not participate. If you do decide to participate and wish to discuss any issues raised following completing this survey, you may wish to take part in the following debriefing process:

- There is a debriefing sheet enclosed with this information pack, please use this to write down any thoughts and feelings you have about filling in the questionnaires. If you choose this can be returned to me with the survey.

- If necessary Stephen Boddington, a Clinical Psychologist and member of course staff at Salomons (South Thames) training course is available to discuss any issues raised by completing this survey. He can be contacted on 01892 507664.

- I will also be happy to talk to you about any issues that taking part in this study raises. Please contact me at my e-mail address: k.m.lee@salomons.org.uk, or by telephone on 01892 507664 (most Fridays). If I am not available please leave a message and I will return your call as soon as possible.

Questionnaires

I have enclosed the survey, which includes four scales that have been previously standardised as well as questions devised by the researcher. This survey should take about 20 minutes to half an hour to complete and it is hoped that you will find it interesting and stimulating. **It would be helpful if you could return the completed survey in the envelope provided by 30th April 1999.**

Your participation is entirely voluntary, all responses will be treated in strictest confidence and all data will be shredded once my analysis is complete in December 1999. If however you would prefer not to participate, I would be most grateful if you could take a moment to complete the last sheet which gives me some information as to how you reached this decision. This will enable me to explore any issues underlying response rate.

If you would like any additional information prior to completing this survey, please feel free to contact me at the above address or telephone number and I will be only to happy to answer any questions you have. I understand that work pressures are consistently high and therefore appreciate the time that you have taken to read this and to complete these questionnaires.

I look forward to hearing from you.

Yours sincerely,

Tina Lee
Psychologist in Clinical Training
South Thames (Salomons) Clinical Psychology Training Scheme
Supervised by Dr. Jane Volans, Consultant Clinical Psychologist, Oxleas NHS Trust

Self Debriefing Sheet

This sheet is provided for you to write about your thoughts and feelings during and after completing these questionnaires. Completing this sheet is optional. If you do chose to complete it you may decide *not* to send it back to me, if however you do send this sheet back with the enclosed questionnaires it will be treated in the strictest confidence.

Information from non-participants

If you decided not to participate in this research, I would be very grateful if you felt able to share with me something of the nature of why you decided not to participate in this research. This will enable me to explore any issues underlying the response rate. This sheet can then be returned in the envelope provided.

Thank you for completing and returning this form.

Request for summary of the results

I would like to thank you again for having taken part in this study. Having completed this survey, if you would like me to send you a summary copy of the results, please write your name and address below and send to me at the following address:

South Thames (Salomons) Clinical Psychology Training Scheme
David Salomons Estate
Broomhill Road
Southborough
Tunbridge Wells
KENT
TN3 0TG

Name: .....

Address: .....

.....

.....

APPENDIX SEVEN

Summary of information from non-participants

Individuals who chose not to complete the questionnaire were asked to describe why they had made this decision. Only fifteen trainees returned non-participation forms and their reasons for non-participation are summarised below:

1. Relatives ill/died recently/older relatives needing support 47% (n=7)

"In the throws of a very difficult time with very elderly parent - bit too close to home"

"Grandma died a few weeks ago"

"Mother died from cancer six weeks ago"

2. Work Pressure 27% (n=4)

"These arrived in essay week and we're all a little bit busy at present"

"Over the past three months, I have been approached by at least four other researchers"

"Too close to thesis hand in - too stressed"

3. Don't know enough re: older people as haven't completed placement/teaching 13% (n=2)

"Know nothing re: elderly work. I've had no teaching yet and haven't had any experience of work in this area"

4. Other 13% (n=2)

"don't feel that the Anxiety about Aging Scale or the Multidimensional Fear of Death Scale are appropriate to be sending out in the post"

"missed the deadline"

APPENDIX EIGHT

Pilot Study

As you are aware, through this research I intend to explore clinical psychology trainees' motivations and barriers to working with older people, by exploring issues such as death anxiety, fear of personal ageing, attitudes to older people, attitudes to psychotherapy with older clients, and experience of working with older people both before and during training. **The nature of this research, for example its focus on anxieties about ageing and death, may raise some personal issues. If for whatever reasons you feel that exploring these issues may be distressing in any way may I suggest that you do not participate.**

It would be very helpful to have your ideas on the following areas and any further comments and thoughts about the questionnaires would be very appreciated.

- ✓ The length of the questionnaire, how long does it take to complete?
- ✓ Is the order of questions appropriate?
- ✓ How does it feel emotionally to complete?
- ✓ Are the items culturally sensitive?
- ✓ Do the questions make sense and are there any typos?
- ✓ Any comments on the presentation e.g. size of print
- ✓ Does the survey format flow well and could I do anything to make it easier to answer?
- ✓ Any suggestions about adding or deleting questions or clarifying the instructions?

Many thanks for taking the time to pilot this study.

Investigating barriers and motivations to working with older people* among Psychologists in Clinical Training in the UK

1. Age: _____ 2. Sex: M F

3. Ethnic origin: _____ 4. Current year of training: 1st 2nd 3rd

5. On qualification I want to work in:

	Not at all					*Very Much*
Child and Adolescent services	1	2	3	4	5	6
Adult Mental Health	1	2	3	4	5	6
Rehab. and Continuing Care	1	2	3	4	5	6
Services for people with learning disabilities	1	2	3	4	5	6
Services for older people (over 65)	1	2	3	4	5	6
Forensic services	1	2	3	4	5	6
Health psychology services	1	2	3	4	5	6
Neuropsychology services	1	2	3	4	5	6
Primary Care Services	1	2	3	4	5	6
Other, please specify_____	1	2	3	4	5	6

6. What factors have influenced your answers to question 5?

_____

_____

_____

_____

Pre-training experience

7. Before clinical psychology training how much did you want to work with older people?

Not at all					*Very much*
1	2	3	4	5	6

8. Do you have some experience of working in services for older people prior to clinical psychology training? *Yes* *No*

a) In what capacity (e.g. Assistant Psychologist, Care Assistant etc.)? _____

b) For approximately how long (years, months)? _____

_____

*Throughout this survey the terms older people and older clients are used to refer to people over 65 years

please continue overleaf

Experience during training

9. During my clinical psychology training **(please tick either a, b, c or d):**

a) I have not yet had any experience of working with older people ❑

b) I have had a placement, with a supervisor, working specifically in services for older people ❑

c) I am currently on placement, with a supervisor, working specifically in services for older people ❑

d) I have gained my core experience with older people across a number of placements ❑

If yes, how many? _____

If you have not worked with older people during clinical psychology training please move on to question 15.

10. Has your experience of working with older people during clinical psychology training made you feel more or less likely to work in services for older people?

Less likely						*More likely*
1	2	3	4	5	6	7

11. How would you rate the quality of your placement with older people?

Very Poor						*Very Good*
1	2	3	4	5	6	7

12. How would you rate the quality of your supervision during your placement with older people?

Very Poor						*Very Good*
1	2	3	4	5	6	7

13. What was the most emotionally rewarding aspect of working with older clients?

_____

_____

_____

_____

_____

14. What was the most emotionally challenging aspect of working with older clients?

_____

_____

_____

_____

_____

please continue overleaf

Psychotherapy with older people

15. In psychotherapy, is it necessary to respond differently and with a modified approach to older clients?

Yes *No*

If yes, what particular factors would you take into account when working with older clients?

16. Working with older people provides the opportunity to apply psychological knowledge and skills?

Not at all						*A great degree*
1	2	3	4	5	6	7

Recruitment

17. Why do you think it may be difficult to recruit clinical psychologists to work with older people?

18. How do you think recruitment to this specialty can be improved?

please continue overleaf

APPENDIX NINE

Psychotherapy with the Elderly Questionnaire

The following is a list of phenomena that may appear in old age. Please decide whether or not the phenomena might hamper your psychotherapeutic work with older people (aged 65 and older) and circle "yes" or "no".

Self-centredness	*Yes*	*No*	Decline in hearing	*Yes*	*No*
Apathy	*Yes*	*No*	Difficulties in memory	*Yes*	*No*
Decline in vision	*Yes*	*No*	Tendency to cry	*Yes*	*No*
Passivity	*Yes*	*No*	Dependence upon care-providers	*Yes*	*No*
Pessimism	*Yes*	*No*	Motor retardation	*Yes*	*No*
Physical malformation	*Yes*	*No*	Difficulty in learning new things	*Yes*	*No*
Decline in orientation	*Yes*	*No*	Impaired physical health	*Yes*	*No*
Mental rigidity	*Yes*	*No*	Neglect of appearance	*Yes*	*No*
Over-talkativeness	*Yes*	*No*	Difficulty in concentration	*Yes*	*No*
Stubbornness	*Yes*	*No*	Not psychologically minded	*Yes*	*No*
Intolerance	*Yes*	*No*	Slow reaction to stimuli	*Yes*	*No*
Suspiciousness	*Yes*	*No*	Difficulty changing habits	*Yes*	*No*
Over-emotionality	*Yes*	*No*	Pre-occupation with the past	*Yes*	*No*
Countertransference Issues	*Yes*	*No*	Please specify _____		

Are there any other phenomena that you feel may interfere with psychotherapeutic work with older people?

please continue overleaf

APPENDIX NINE

Aging Opinion Survey

The statements you are going to read are opinions. Anyone could agree with some of them and object to others. The question is which are the opinions with which *you* agree or disagree. Please indicate your judgement about each idea expressed by circling a number between 1 and 9. The low numbers 1, 2, 3 and 4 mean some degree of disagreement and the high numbers 6, 7, 8 and 9 mean some degree of agreement. Five then means you have no opinion one way or the other. Only circle one number between 1 and 9 for each sentence. Do not stop to think too long about the statements, all that is wanted is your first reaction.

		DISAGREE					*AGREE*	
Strongly			*a little*		*a little*			*Strongly*
1	2	3	4	5	6	7	8	9

1. Community organisations would function more smoothly if older persons were included on their governing boards 1 2 3 4 5 6 7 8 9

2. The older my friends get the less respect they have for the privacy of others 1 2 3 4 5 6 7 8 9

3. Old people usually interfere with their adult children's child-rearing practices 1 2 3 4 5 6 7 8 9

4. I would prefer to always live in an area where people my age predominate 1 2 3 4 5 6 7 8 9

5. I would always want to live in a neighbourhood where there was a variety of age groups 1 2 3 4 5 6 7 8 9

6. After retirement one should not have much influence in public policy making 1 2 3 4 5 6 7 8 9

7. Most people I know feel that the elderly deserve a great deal of admiration 1 2 3 4 5 6 7 8 9

8. The elderly have a wealth of knowledge and experience that is not sufficiently utilised 1 2 3 4 5 6 7 8 9

9. Youthful enthusiasm and fresh ideas should count for more in today's world than the outdated notions of the older generation 1 2 3 4 5 6 7 8 9

10. The elderly are one of our great undeveloped natural resources 1 2 3 4 5 6 7 8 9

11. Older people are more or less a burden for the young 1 2 3 4 5 6 7 8 9

12. Society would benefit if the elderly had more say in government 1 2 3 4 5 6 7 8 9

13. Most elderly prefer to live in senior citizens apartment buildings 1 2 3 4 5 6 7 8 9

14. The elderly shouldn't be expected to do more for society after they retire 1 2 3 4 5 6 7 8 9

15. Neighbourhoods where the elderly predominate often become run down 1 2 3 4 5 6 7 8 9

please continue overleaf

APPENDIX NINE

Anxiety About Aging Scale

Please indicate the extent to which you agree or disagree with each of the following statements by circling the appropriate number following each item based on the rating scale provided below.

	Strongly disagree	Mildly disagree	Neither disagree or agree	Mildly agree	Strongly agree
1. I enjoy being around old people	1	2	3	4	5
2. I fear that when I am old all my friends will be gone	1	2	3	4	5
3. I like to visit my older relatives	1	2	3	4	5
4. I have never lied about my age in order to appear younger	1	2	3	4	5
5. I fear it will be very hard for me to find contentment in old age	1	2	3	4	5
6. The older I become, the more I worry about my health	1	2	3	4	5
7. I will have plenty to occupy my time when I am old	1	2	3	4	5
8. I get nervous when I think about someone else making decisions for me when I am old	1	2	3	4	5
9. It doesn't bother me at all to imagine myself as being old	1	2	3	4	5
10. I enjoy talking with old people	1	2	3	4	5
11. I expect to feel good about life when I am old	1	2	3	4	5
12. I have never dreaded the day I would look in the mirror and see grey hairs	1	2	3	4	5
13. I feel very comfortable when I am around an old person	1	2	3	4	5
14. I worry that people will ignore me when I am old	1	2	3	4	5
15. I have never dreaded looking old	1	2	3	4	5
16. I believe that I will still be able to do most things for myself when I am old	1	2	3	4	5
17. I am afraid that there will be no meaning in life when I am old	1	2	3	4	5
18. I expect to feel good about myself when I am old	1	2	3	4	5
19. I enjoy doing things for old people	1	2	3	4	5
20. When I look in the mirror, it bothers me to see how my looks have changed with age	1	2	3	4	5

please continue overleaf

APPENDIX NINE

Multidimensional Fear of Death Scale

Listed below are death-related events and circumstances that some people find to be fear-evoking. Indicate the extent to which you agree or disagree with each statement by circling <u>one</u> number for each item. Do <u>not</u> skip any items if you can avoid it.

	Strongly disagree	Mildly disagree	Neither disagree or agree	Mildly agree	Strongly agree
1. I am afraid of dying very slowly	1	2	3	4	5
2. I dread visiting a funeral home	1	2	3	4	5
3. I would like to donate my body to science	1	2	3	4	5
4. I have a fear of people in my family dying	1	2	3	4	5
5. I am afraid that there is no afterlife	1	2	3	4	5
6. There are probably many people pronounced dead that are really still alive	1	2	3	4	5
7. I am afraid of my body being disfigured when I die	1	2	3	4	5
8. I have a fear of not accomplishing my goals in life before dying	1	2	3	4	5
9. I am afraid of meeting my creator	1	2	3	4	5
10. I am afraid of being buried alive	1	2	3	4	5
11. I dread the thought of my body being embalmed some day	1	2	3	4	5
12. I am afraid I will not live long enough to enjoy my retirement	1	2	3	4	5
13. I am afraid of dying in a fire	1	2	3	4	5
14. Touching a corpse would not bother me	1	2	3	4	5
15. I do not want medical students using my body for practice after I die	1	2	3	4	5
16. If people I am very close to were to die suddenly, I would suffer for a long time	1	2	3	4	5
17. If I were to die tomorrow, my family would be upset for a long time	1	2	3	4	5
18. I am afraid that death is the end of one's existence	1	2	3	4	5
19. People should have autopsies to ensure that they are dead	1	2	3	4	5
20. The thought of my body being found after I die scares me	1	2	3	4	5
21. I am afraid I will not have time to experience everything I want to do	1	2	3	4	5

please continue overleaf

APPENDIX NINE

Multidimensional Fear of Death Scale (continued)

	Strongly disagree	Mildly disagree	Neither disagree or agree	Mildly agree	Strongly agree
22. I am afraid of experiencing a great deal of pain when I die	1	2	3	4	5
23. Discovering a dead body would be a horrifying experience	1	2	3	4	5
24. I do not like the thought of being cremated	1	2	3	4	5
25. Since everyone dies, I won't be too upset when my friends die	1	2	3	4	5
26. I would be afraid to walk through a graveyard, alone at night	1	2	3	4	5
27. I am afraid of dying of cancer	1	2	3	4	5
28. It doesn't matter whether I am buried in a wooden box or a steel vault	1	2	3	4	5
29. It scares me to think I may be conscious while lying in a morgue	1	2	3	4	5
30. I am afraid to think there may not be a Supreme Being	1	2	3	4	5
31. I have a fear of suffocating (including drowning)	1	2	3	4	5
32. It would bother me to remove a dead animal from the road	1	2	3	4	5
33. I do not want to donate my eyes after I die	1	2	3	4	5
34. Sometimes I get upset when acquaintances die	1	2	3	4	5
35. The thought of being locked in a coffin after I die scares me	1	2	3	4	5
36. No one can say for sure what will happen after death	1	2	3	4	5
37. If I die, my friends would be upset for a long time	1	2	3	4	5
38. I hope more than one doctor examines me before I am pronounced dead	1	2	3	4	5
39. I am afraid of things which have died	1	2	3	4	5
40. The thought of my body decaying after I die scares me	1	2	3	4	5
41. I am afraid I may never see my children grow up	1	2	3	4	5
42. I have a fear of dying violently	1	2	3	4	5

please continue overleaf

Are there any further comments you would like to make about working with older people and/or the process of completing this survey?

Thank you very much for taking the time to complete this questionnaire.

Please return in the envelope provided to:

Tina Lee
Psychologist in Clinical Training
South Thames (Salomons) Clinical Psychology Training Scheme
David Salomons Estate
Broomhill Road
Southborough
TUNBRIDGE WELLS
Kent, TN3 0TG

please continue overleaf

Salomons Centre
David Salomons Estate
Broomhill Road, Southborough
TUNBRIDGE WELLS
Kent TN3 0TG

Telephone: 01892 515152
Facsimile: 01892 539102

Our Ref: AL/LT/075
Direct Fax: 01892 518446
E-mail: t.lavender@salomons.org.uk

SALOMONS
CENTRE

Ms K Lee
11 Portland Villas
Hove
East Sussex
BN3 5SA

29th January 1999

Dear Tina,

Re: Ethics Approval - Investigating motivations and barriers to working with older people among psychologists in clinical training

The Ethics Panel is pleased to provide full ethical approval for your research project. The Panel were impressed with the thoroughness of the proposal and the way in which the ethical issues had been considered and taken into account.

There were a number of minor issues:

1. Page 7, 2nd line from the bottom. You have in other places in the report guaranteed confidentiality and if the procedures described are followed this should be achieved. It is important to guarantee confidentiality from an ethical point of view.
2. Page 3. Questionnaire in the text should be questionnaires.
3. Page 32, line 3. Need to leave out a "to".
4. It would be advisable to send a brief report of the findings to Course Directors.
5. It would be helpful to give a time estimate about when the analysis will be completed.

We wish you well with the project and would be extremely interested to see the results.

Yours sincerely,

Professor Tony Lavender
Chair of Ethics Panel

c.c. Caroline Hogg
Nigel Armstrong

APPENDIX ELEVEN: CODING FRAMES

What factors have influenced your work preference? (Total N=371)

1. Previous experience/previous work

"my previous experience working in these areas"
"prior experience"
"experience in primary care does not give me a buzz, learning disability work does having been an Assistant there"
"the others I have some experience of and do not wish to work further with them"
"previous experience or lack of experience in these areas"

2. Training / placement experience

"experiences so far on placements"
"placement experience (positive and negative)"
"my training placements. In fact I was surprised that I enjoyed my older adult's placements since I had not expected to as much as I did"
"previous experience modified by quality of placements"
"my training to date"
"the quality of core and specialists (forensic) placements"
"experience as a trainee"
"my experience to date as a psychologist in training"

3. Personal preference / own interest / personal qualities

[Personal choice, outside interest]
"personal interests"
"outside interests (e.g. British Sign Language)"
"personal choice and interest in specific areas within specialties"
"personal interest - least personally distressing areas to work in"
"knowledge of my own personality and abilities"
"examining the personal skills I have to offer and where at the moment I believe they would offer the best service"
"personal orientation/opinions"
"specifically severe mental health as this is where my personal interests lie due to experiences within my own family"
"personal factors"

4. Enjoyment / satisfaction / stimulating / challenging

"anticipated enjoyment"
"previous enjoyment"
"enjoyment of placements"
"did not enjoy child or LD work"
"found adult work more stimulating"
"enjoyment of work with these populations"
"areas chosen stimulating, challenging"
"job satisfaction"
"things that I have enjoyed (or not) from my experiences so far"
"I found this work fascinating, creative and challenging"
"my older adult placement however was very enjoyable and I have since contemplated working with older adults"
"challenging and rewarding client groups"

5. Previous assistant psychologist experience

"previous experience working as an assistant"
"prior to course as an assistant"
"a very good assistant post in older adult services"

"previous assistant experience - specialties already had experience in (e.g. LD) would like to work in"

6. Lack of experience and lack of confidence in the area / too early to decide
"I have not rated anything as 6 as I am waiting until I complete my training to decide"
"may obviously change as get more experience"
"yet to experience other fields, but I may have a different opinion at the end of the course"
"I feel that 5 months in training is not enough time to decide"
"haven't worked in other areas so difficult to hard to say whether I'd like to work in them"
"I have no real idea at the moment especially as I've not worked in LD or child or rehab during work in psychology yet"

7. Diversity, variety and flexibility of post
"flexibility"
"interesting and varied"
"diversity of theoretical models/approaches to working. Variety of caseload"
"the desire to work with a range of age groups and problems"
"interest in forensic based upon complexity of cases and varied nature of work"

8. Interest / preference for a particular theoretical model more associated with client group
"I have interests in cognitive therapy, psychotherapy and neuropsychology. As such, these interests would be best met in adult or older adult services"
"Prior to clinical training I was training as a counsellor and have become more interested in psychotherapy issues, particularly in physical health care settings"
"theoretical approach tendencies e.g. adult: psychodynamic and cognitive; child: systemic, narrative"
"systemic versus more individual issues"

9. Academic issues / research
"I am interested in neuropsychology from an academic perspective"
"final year research topic"
"research interests"

10. Ability to impact / speed of change / difficulty
"anticipated impact on client, depth of intervention"
"I felt that clients in primary care made rapid improvements and this gave me high job satisfaction"
"relatively little impact, change is slow, little hope of change"
"experience that the earlier you can treat a problem e.g. in childhood you have a better chance of preventing pathological development of that problem to more serious disorder"
"content of the job - rehabilitative versus maintenance"

11. Teaching and reading
"Re: older adults. My training course provided very good teaching about older adults work"
"teaching on the course"
"academic teaching"
"reading from undergraduate years"
"interest stimulated by reading the literature"

12. Work conditions
"I also would like to work in a general hospital setting at some point, hence health psychology"
"quality of supervision"
"experience of an isolated way of working also affected my decision (prefer team working)"
"major influence of any choice of job is the department members"
"much room for development and improvement of services"

"Also I am keen to work in areas which I perceive as being better resourced"

13. Enthusiasm for client group / relating or not relating to client group
"found child work hard in terms of communicating with kids"
"I have always wished to work with children and have entered clinical psychology training to achieve this aim"
"enthusiasm for client group whilst on placement"
"interest in one specific group of clients"
"I relate more to older adults, children and adults but not to people with learning disability and forensic patients"

14. Confidence / understanding / knowledge
"lack of confidence in training experience and knowledge to do this"
"I want to work in an area I have more experience and confidence"
"understanding the type of work undertaken"

15. Opportunities for employment
"opportunities for employment"
"job opportunities in specific departments"
"good career prospects"
"job availability, desire for early promotion"

Miscellaneous

Missing

APPENDIX ELEVEN: CODING FRAMES

What was the most emotionally rewarding aspect of working with older clients during your older adult placement? (Total N=178)

---

1. Impact of psychological interventions

[psychological interventions leading to improvements or potential for making a difference, being able to help, improving client's quality of life, a sense of accomplishment]

"working effectively with a client who overcame his phobia and was able to function more independently once more"
"ability to support a person in need, to see change"
"improving quality of life"
"seeing people get better"
"helping people prepare for their final years. Encouraging empowerment and independence"
"good outcome from therapeutic interventions"
"trying to help them"
"helping people find new meanings and sense in the life they have led and in who they are"
"helping people overcome difficulties in later years"

2. Hearing life stories

[enjoying talking to people from different generation and with rich life experiences, talking/listening to older people]

"hearing people's stories - a great privilege"
"to be the recipient of a life story"
"finding out so much about social history"
"generally enjoying talking to older people"
"the rich life experiences that they have had"
"hearing about their accounts of past events e.g. wartime, relationships, the 'ups' and 'downs' of life and how these were negotiated by couples/single people at an emotional level"
"listening to life stories and hearing about war experiences for example - breadth of experience not just length"

3. Gratitude / feeling appreciated / valued by clients

"the gratitude the elderly clients often openly express following input from psychology"
"their pleasure at seeing me"
"older clients seemed more appreciative of my input"
"they gave me encouraging feedback which was new compared to other client groups"
"how pleased they were to see you"
"feeling your input is valued"
"being appreciated for doing very little"

4. Clients themselves/the relationship with the client

[client's characteristics associated with their age, clients were pleasant, open and direct, polite, friendly, they turned up for appointments, enjoying their company]

"the individual clients were all very pleasant and co-operative despite their negative thoughts"
"developing rapport / an alliance with older people"
"pleasant population to work with"
"their gentle nature, different values from life"
"connecting with people"
"the rapport which can develop can be quite rewarding"
"the contact with clients"
"their enthusiasm and sense of humour (very generally)"

5. Greater capacity for improvement

[Clients were more engaged in therapy and more motivated to change, psychology could impact more significantly than with other groups, wealth of experience to draw on, different expectations of therapy]

"level of motivation and commitment to work. Their willingness to accept and be interested"

"able to bring depth of experience to therapy"
"older clients seem less well served than other clients, therefore it felt as though there were a lot of ways psychology could make a difference"
"the efforts that individual clients made in treatment were often great which in most cases led to very successful interventions"
"appreciating how open and responsive older clients are to change and psychological ways of thinking although obviously this was easier for some than others"
"older clients were more willing to work with me in order to resolve their difficulties"

6. Therapeutic approach / techniques

[e.g. existential, life review, using variety of approaches, type of work - family and staff, individual sessions, system level interventions, variety of work involved]
"to be able to work in an existential framework"
"able to implement different models"
"working in a family context"
"I find the 'reflective / reminiscence' type of work which is often central to older adult work very rewarding"
"one-to-one therapeutic work"
"doing long-term therapy including life review"
"variety of presentations, situations, people seemed immense"

7. Changing attitudes - self

[realising change can occur regardless of age, seeing old age more positively, challenging assumptions / stereotypes]
"seeing that change can and does still occur for the benefit of the client regardless of their age"
"challenged some of my stereotypes"
"increasing awareness that the problems of later life do not have to result in depression or despair"
"realising how much these people have to say and need to be heard"
"opportunity to challenge my own preconceptions of what it means to grow old"
"I think it changed my view of later life to one of realising that this can be a time of growth or change"

8. Learning from / understanding older adults' experiences

[learning how they have coped e.g. with dementia, their resilience and a lifetime of coping resources]
"learning from their vast range of experiences"
"working with people who have a lifetime of coping resources"
"their determination, openness to change, genuineness and strength considering they are alone and isolated with physical difficulties"
"their resilience sometimes in the face of considerable adversity"

9. Nothing

"I really can't honestly think of one"
"wasn't really emotionally rewarding"
"I felt my experience was very negative"

9. Working atmosphere

"working in a good team and co-working with other professionals feeling part of a service"
"supportive staff and MDTs"
"enjoyed multidisciplinary approach"

11. Practicalities

"time for reading"
"having time
"practicalities were easier"

APPENDIX ELEVEN: CODING FRAMES

11. Changing attitudes - others
"helping people understand that people can still have a satisfactory life despite having a dementia"
"showing that improvement was possible when others viewed the client negatively"

11. Don't know / not sure
"difficult to say"

Miscellaneous

Missing

APPENDIX ELEVEN: CODING FRAMES

If you think it is necessary to respond differently and with a modified approach with older people, what factors would you take into account when working with this group?
(Total N=371)

---

1. Cognitive decline/adjust for memory difficulties/dementia

[memory aids, concentration]

"if memory problems are present I believe psychotherapy needs to be modified and incorporate such difficulties"
"deterioration of memory / intellectual capacities"
"dementia or general slowing"
"level of cognitive functioning"
"with memory problems may have to write things down, repeat things etc."
"memory, information processing, speed, possible dementia"
"co-morbid problems associated with older clients e.g. dementia, pseudodementia"
"organic changes e.g. dementia"
"concentration span"

2. Physical health problems / sensory impairment / mobility

[effecting therapeutic work and access]

"Awareness of possible sensory decline"
"adapt to physical disabilities"
"I suppose common issues for older clients may include physical ill health"
"general eye on health"
"issues relating to physical health and how it interacts with mental health"
"must consider motor and cognitive slowing and the possibility of sensory deficits - would all affect way you engage in therapy"
"physical problems as a result of the ageing process"
"only in terms of presentation of material (verbal and visual) to take account of any loss of vision or hearing"

3. Age differences/Cohort effects

[older people have different life experiences, different cultural norms, different values, different life stage, developmental factors and tasks, different needs and goals, societal changes]

"not to be assumed but attention must be paid to different cultural experiences from the generations"
"consider developmental factors"
"issues of stage of life they may be at, important in therapy"
"relate therapy to life span issues, give them space to make explicit their experiences and goals which may differ from other client groups"
"generational differences in attitudes"
"awareness of societal changes"
"to a degree a person's life stage must be taken into account. Thus at 65 years there may be different issues to a person of 25 years e.g. life style changes (retirement)"
"generational issues - environment, society that they grew up in will be very different to the way things are now"

4. Psychological mindedness/explaining psychological approach

[less psychologically aware, noticed to talking therapies, used to alternative coping strategies, attitude to therapy: alien, suspicion of psychology, more time to explain your role and approach and establish the therapeutic relationship, ability to engage in therapy]

"not as psychologically minded"
"take into account different views of psychotherapy and how to deal with life problems"
"to explain more clearly the concepts involved in therapy"
"consider the possibility that older people may be more inclined to view therapy as more alien to them than younger people and may regard it as a sign of weakness"

"their understanding of psychological maters may be outdated or relatively non-existent, they may find it more difficult to understand lots of jargon / explanation etc."
"the fact that they are poorly socialised to the psychological model"
"may take more time to explain concepts"
"clients often find monitoring forms an alien concept"
"longer engagement - familiarisation with psychological ways of thinking"

5. Particular problems for older adults
[focus on bereavement, loss, death, less years to live, disability, endings may be an issue, life review]
"perhaps more emphasis on loss and despair and evaluation of a client's life"
"tasks peculiar to that age group e.g. life review / integration"
"issues of bereavement more pertinent in this group"
"increased likelihood of life changes (e.g. death, retirement) more focus on quality of life improvements"
"life stage issues of loss, including bereavement, job, status, change in own role, facing old age, physical deterioration, loss of abilities and own death"
"awareness of growing incapacity - very frustrating. Loss of dignity."

5. May need to adapt to individual regardless of age
[depends on the individual's needs, difficult to generalise, can't make assumptions, use same basic skills with any age group]
"necessary to work with the clients' understanding of their problems (like all therapy I suppose)"
"I try to look at each person as an individual so I wouldn't respond differently to any other person I met in psychology"
"use of the same basic skills and the need to formulate for the individual are the same"
"depends on the individual and their presenting problem"
"having to chose 'yes' or 'no' presupposes that older clients are a homogenous group of people, which I don't feel is the case more than for any other age group"
"modify only as much as would for clients in AMH"

7. Less directive / more flexible (in time, settings and number of sessions)
[less theoretical, loser boundaries, more concrete, modify record keeping, consider vocabulary used and communication difficulties, less jargon]
"more concrete emphasis i.e. less what might be perceived as 'psychobabble'"
"more creative ways of applying a cognitive approach"
"jargon e.g. 'How have you been in your spirits?'"
"number of sessions, length of sessions"
"barriers to communication are more evident"
"different vocabulary used by different generations"
"being more self-disclosing if appropriate"
"explanations of models can seem trite - ended to avoid and adopt a more of a counselling approach at times"
"ability to work in a pure CBT /psychodynamic way therefore use of life review"

8. Allow more time / go slower / consider pace / speed of change
" I might allow more time for information processing"
"speed of change"
"slightly slower pace (always at clients' pace as in any psychotherapy"
"pace of therapy - much slower"
"increase time - tendency to be diverted / chat"

9. Age of therapist / transference issues
[Impact of age gap on work in sessions]
"transference and countertransference"
"potentially different client-therapist relationship due to age difference between them"

"them seeing you as young and not knowing anything"
"specific transference issues i.e. dependency"
"need to address difficulties in age difference - the client can treat you as a daughter etc."

9. Current socio-economic situation / social support / coping strategies
"current life circumstance"
"greater consideration of their support context"
"financial issues"
"resources and future social context"
"with all clients it's important to take into account the wider social and service context. With other people that might include e.g. negative social attitudes, environmental issues e.g. residential homes"
"need to consider therapy in terms of the effects of older peoples' position in society"

11. More life experience
[need longer assessment, have more experience to draw on, coped with crises in the past]
" I expect that the longer life history may mean that assessment is longer in some cases"
"increased number of life events"
"sensitivity to the vastness of their life experience"
"life experiences, strength to live through life crises - coping abilities"

12. Less motivated to change / more rigid / longer history of problem
"may be less willing to change their ways"
"the duration of difficulties might imply deeply ingrained patterns of thought and behaviour which are indistinguishable from personality"
"inflexibility - difficulty learning new things and taking on new perspective about themselves"
"acceptance may be more necessary than motivation to make significant changes or decisions"

12. Don't know / not sure / no experience of working in this area yet
"no clear ideas on this as so far not covered by teaching or work experience"
"don't know too much about this"

14. CBT or challenging beliefs was difficult as problems are real
[need to set realistic goals]
"I found working purely CBT with some clients quite difficult"
"more realistic negative thoughts e.g. 'all my friends are dead or disabled"
"reality of negative beliefs not necessarily pathological"

14. Focus of work
[may need to work with families, carers, institutions etc. as well as individual]
"more interaction with systems than with some other groups (family, residential placements)"
"may wish to involve relatives / caregivers in therapy / care"
"family perspective important"

Miscellaneous
[including respect, depends on model being used, whether the client themselves requested therapy, the importance of MDT work, existential issues, the difficulty of exploring some issues which may be too traumatic]

Missing

APPENDIX ELEVEN: CODING FRAMES

What was the most emotionally challenging aspect of working with older clients during your older adult placement? (Total N=178)

---

1. Situation of clients/multiple of losses

[reality of situations, depressing and sad situations, clients facing death, physical and mental deterioration, illness, isolation and social issues]

"working with much sadness and loss - loss of loved ones, relationships, autonomy, freedom, functioning (social, psychological, cognitive, etc.)

"some clients facing almost intolerable prognosis"

"loneliness, isolation, social issues"

"knowing that in many cases the problems people faced were very real and not necessarily amenable to interventions - led to re-evaluation of aims and objectives with clients"

"witnessing chronic, disabling illness"

"feeling so desperately sorry for them - the loss, death, bereavement, illness, poverty, loss of dignity, abuse. Horrible!"

"dealing with decline - memory, loss, incontinence etc."

"feeling there was little I could do to deal with the source of some of their difficulties such as loneliness after death of a spouse, physical disability as a result of chronic illness and the impact of many years of chronic depression"

"some people's intense loneliness and feelings of loss"

"presence of multiple problems made me feel overwhelmed/helpless"

2. Feeling incompetent / overwhelmed / helpless / hopeless

[feeling unknowledgeable/unskilled/young and inexperienced, slow progress, little possibility of change not enough time left, acceptance rather than change, their feelings of regret, clients behaviour patterns more entrenched, problems were long standing, complex cases, client and therapist feeling "what's the point?"]

"the sense that the habitual stance people adopt to their past issues becomes very firmly entrenched"

"very hard if there's little improvement - more so than with younger clients"

"the sense of there not being enough time left"

"progress did seem slow I felt quite de-skilled"

"some very entrenched difficulties due to long-standing nature"

"feeling young, inexperienced and helpless"

"feeling frustrated and despondent at slow progress or the person's unwillingness to engage"

"trying to convince an elderly (depressed) man that he had something worth living for"

"patterns of behaviour are long-standing"

"sense of hopelessness, little possibility of change after 70 years of life"

"pessimism on their part"

"being unable to see any hope for a client. Predicting continued decline"

3. Working with people with dementia and their families

[witnessing deterioration]

"most of my work was with people with dementia - this is emotionally challenging as I had the feeling that they were going to deteriorate and this was sad"

"loss associated with dementia"

"visiting inpatients who are in the end stages of dementia"

"helping clients and their families come to terms with the effects of dementia"

4. Personal impact

[concerns re: own or relatives' ageing and mortality, concerns re: bereavements and dependency in own old age, concerns re: dementia, impact of current personal situation e.g. recent bereavements]

"awareness of my own parents and relatives becoming older"

"being faced with issues about my own death"
"working with a lot of people who had been bereaved or were suffering from dementia and thinking about how likely both issues were to affect myself or a partner in old age"
"also cognitive decline as I kept looking at my mum and looking for signs of it!"
"working with clients facing death or having been bereaved, this brought up personal issues about how I see my own mortality and my experience of bereavement"
"coping with death of clients"
"imagining how you would cope if in their position"

5. Disclosing diagnosis of dementia, carrying out assessments for dementia
[breaking bad news in general]
"feeding back assessment results to carers and the individual, especially when prognosis is poor"
"disclosure of diagnosis of dementia and poor results on driving assessment"
"having to do neuropsychological testing, seeing people struggle with the tests and realising their losses"

5. Attitudes of others to older people
[shortfalls in services, working with care staff, working in services that didn't meet needs, poor resources e.g. private nursing homes, difficulty challenging the system]
"attitudes of staff in hospital towards the clients"
"the ignorance and lack of training of many of the care staff in residential homes"
"poor resources"
"working with systems which often have agendas which aren't always related to clients needs"
"the quality of the service environment in which some people had to live and the apparently insurmountable difficulties facing anyone who wanted to try and change this (attitudes, resources, etc.)"
"a rather paternalistic / patronising attitudes towards the client group"

7. Perceived difficulties working psychologically with older adults
[client seeing you as their child or a 'young upstart', difficulty introducing psychological ideas]
"convincing them psychology can help them"
"feeling that it must be very patronising to have 'some young upstart' make any claims of being able to understand/help"
"difficulties in introducing alternative thinking"

8. Dominance of medial model / psychiatrists
"the medical treatment of people and its assumption that any unusual behaviour was a sign of organic pathology"
"sometimes frustrating to work in the older people services - a disillusionment about the medicalisation of lack of thought of psychology within my placement service"

9. Placement / supervisor issues / lack of support
"I think it was the nature of the placement and supervision which were 'challenging' rather than the client group"

9. Nothing
"little emotional challenging"
"wasn't emotionally challenging"

Miscellaneous
[including inappropriate referrals and communication difficulties]

Missing

APPENDIX ELEVEN: CODING FRAMES

Why might it be difficult to recruit to the older adult specialty? (Total N=371)

1. Less rewarding/less impact of psychological approaches/positive outcomes or significant improvements are less likely

[less opportunity to work psychologically, limited capacity for change, client and/or therapist's view that there's little time to benefit due to decreased life expectancy, clients not psychologically minded, clients are more rigid and problems more entrenched, clients deteriorate and may have long term problems or more complex problems, progress can be slow, hard and challenging work]

"sometimes cases are more complex leading to less discernible results"
"it may be viewed as an area in which change/improvement in clients is limited/slow"
"viewed as a palliative form of care rather than hoping to 'cure' somebody"
"limited reward"
"perhaps feels not a lot of therapeutic work can be done with older age group"
"may feel pointless"
"fear that work will seem futile and/or depressing"
"the long term problems may be more difficult to work with"

2. Personal issues/facing ageing, death, bereavements/emotional challenge/difficult to relate to people from this age group/clients more likely to die

[depressing work, fears of ageing, impact on trainees' current life circumstances, people's perception that the work is all loss and death, dementia and depression]

"nature of work may be perceived as too depressing"
"anxiety re: inevitability of old age for oneself"
"perhaps psychologists are afraid of old age and death and issues to do with loss"
"working with older adults can tap into emotionally powerful issues for the therapists: I found it quite challenging having to think about issues around dementia and death"
"demotivating to have clients die on you all the time"
"too close to home"
"people who are personally close to relatives who are very old (near death) might find the work distressing"

3. Unattractive specialty / poor image / low profile

[low status, not cutting edge, not as glamorous, fashionable or sexy as other specialties, dislike of client group, not exciting or challenging or dynamic, lack of kudos, unpopular in comparison to other specialties]

"because it's seen as unchallenging and unexciting"
"it doesn't seem to have the same status as other areas. think it is viewed as less innovative and less dynamic"
"services (and psychologists) still look down on this kind of work"
"other specialties may be more appealing"
"not seen as an up and coming area"
"not as 'trendy' to work with"
"they are not particularly attractive"

4. Ageism / prejudice / old age bias

[attitudes to older people, marginalisation in wider society, stereotypes]

"ageist attitudes in society, prejudices"
"stigmatised group"
"it is a devalued group and therefore I believe psychologists may feel devalued or believe they will be in this area"
"we live in a time when productiveness is highly appreciated. Older people can't be so productive, so not valued so much in our society"
"general psychology world attitudes to older adults"

5. Training / experience issues
[lack of experience, bad placement experience, timing of placement, shortage of placements, poor quality teaching]
"given little attention during training"
"lack of good placements"
"not guaranteed to get an older adult placement, so people may not get a chance to see what it is like (and find they like it).
"it may be that courses don't promote working with older adults in a positive way or perhaps the teaching isn't as interesting and inspiring as in other specialties"
"low exposure during training"
"less assistant psychology posts in older adult specialties, fewer placements therefore difficult to feel competent in this area or develop specific interests"

6. Working environment / working with families, carers and organisations
[lack of well developed services, poor quality services, depressing environments]
"questionable standards of care e.g. private homes"
"because of the poor quality of MDT workers (patronising, own power issues, non-empowering), have to work in dysfunctional systems"
"settings can be pretty depressing - e.g. wards and often other staff can be less skilled and under-trained"
"carers and family less willing to persevere"
"depressing working in institutions"

7. The work is mainly neuropsychological assessments/limited role
[lack of variety in work, emphasis on neuroassessment rather than psychotherapy: either a belief that this is the case or past experience which has born this out]
"may hold the view that it's just about dementia assessment, bereavement, counselling etc. or that it is more limited"
"because for many people their experience is gained in a setting where skills in testing and assessment is more frequently utilised that skills in psychotherapy (this is not my experience however)"
"I think there's an expectation that older adult work is restricted to cognitive assessment e.g. for dementia and depression issues and not much else"
"a good deal of the work involving neuropsychology testing and behavioural programmes(!)"
"because of the limited role given to clinical psychologists in the treatment and management of organic disorders, role perceived as neuroassessment by MDTs"

7. Supervision / lack of support / lack of well developed services
[few good role models, too few psychologists working in the specialty, isolation, smaller departments]
"not many psychologists working in the field therefore may appear quite isolated"
"it's a viscous circle. There are only a few supervisors and even fewer elderly departments"

9. Limited resources and lack of funding
"it is an under-resourced field"
"doesn't attract funding"
"poor provision of services"

9. Psychological models / therapies haven't been applied
[theories not as well developed, less research]
"little opportunity for research"
"traditionally viewed as unable to apply therapeutic models"
"lack of awareness of advances in psychotherapy with older adults"
"small research base, lack of comprehensive unitary models for understanding ageing and ageism"

11. Medicalised / non psychological philosophy
[limited therapeutic ethos, older people's psychological needs aren't recognised]
"dominance of psychiatry"
"ageist notions that older people don't need psychological interventions"
"tendency for older people to 'somatise' problems"
"perceptions that physical problems more prominent"

12. Poor opportunities for professional development
[reluctance to become too specialised, 'boxed in' to older adult specialty]
"becoming too specialist in one area"
"clinical psychologists may not consider that there is much opportunity for professional development in this area"

12. Don't know / not sure / unaware it was an issue
"haven't a clue"
"I wasn't aware that it was any more difficult recruiting clinical psychologists to older adult services that it is to either neuropsychology or learning disability services"

Miscellaneous

Missing

APPENDIX ELEVEN: CODING FRAMES

How do you think recruitment to this specialty could be improved? (Total N=371)

1. Good quality older adult placements and/or teaching on training courses
[maintaining core experience of working in older adult specialty, changing timing of older adult placement, ensuring good quality of placement and teaching, emphasising a variety of work in teaching, encouraging positive attitudes, encouraging research by trainees]
"good quality older adult placements as part of clinical psychology training should be protected rather than done away with"
"ensuring that older adult placements are maintained as part of the curriculum rather than being diluted (this was important for me anyway)"
"greater emphasis during training"
"offering good placements to trainees - always a good incentive to working in a specialty"
"good supervision for trainees"
"earlier experience with older adults on training courses"

2. Improved marketing of the role of older adults psychologists
[more accurate information, increased knowledge re: working with older adults, changing nature of work, changing way services are valued, variety of work, role of clinical psychology, what are positive aspects of working with older people, what improvements and changes can be made, more research]
"increasing knowledge about the variety of work in older adult specialties (e.g. publications in Forum"
"national campaign to increase the awareness of the work that can be achieved and increase the prestige of working with this client group"
"improving profile of what work occurs and dispelling myths"
"higher profile at university undergraduate level of working with older adults"
"continue to promote the specialty (PSIGE etc.)"
"promoting it as a developing clinical area, new approaches/opportunities to work with older adults"

3. Improved terms and conditions/more support
[posts are more attractive as more posts are filled, opportunity for research and CPD, support of professional and personal development, more contact between psychologists, developing specialist interest groups e.g. PSIGE, combat feelings of isolation]
"CPD and offering it as part of recruitment package"
"support personal development"
"clearer job descriptions"
"offer of good supervision. Further training opportunities"
"emphasise possible research opportunities"

4. Don't know / not sure
"I find this difficult to answer as personally I feel the work with older adults is not for me"
"no idea"
"don't feel qualified to comment"

5. Higher pay/more funding for posts
"larger salaries"
"more funding for posts"
"more money being brought to the specialty can only bring more benefits"
"increased funds so can have at least two older adult psychologists in a department"

6. More split posts
"opportunities of joint specialties"
"link the area more to other areas - both theoretically and practically"

"job shares"
"it's possible that split posts are more attractive so that psychologists don't feel stuck in one area"

7. Better resources/working conditions
[quality of services to older adults, more funding for services, more resources, improving environments]
"provide more resources"
"by improving working conditions for paid carers"

7. Changing in society's attitudes
[tackling ageism, more positive role models in media, psychologists' role in terms of education and training, more positive social representations of older age]
"more positive role models in the media"
"confronting ageism as the prejudice it is (along with sexism and racism). The problem of negative attitudes to older adults seem to exist across the whole society and not just psychology so ultimately this needs to be addressed"
"society's stereotyping of older people needs changing first"
"greater efforts to raise the profile of ageism within society"

9. Changing service organisation
[is a specialist older 65 service necessary?]
"specialist - generic services"
"consider changing the system e.g. older adult within AMH services and specialists in particular issues e.g. dementia, regardless of client's age"
"make it more continuous with adult work so people are seen as adults first, elderly second"

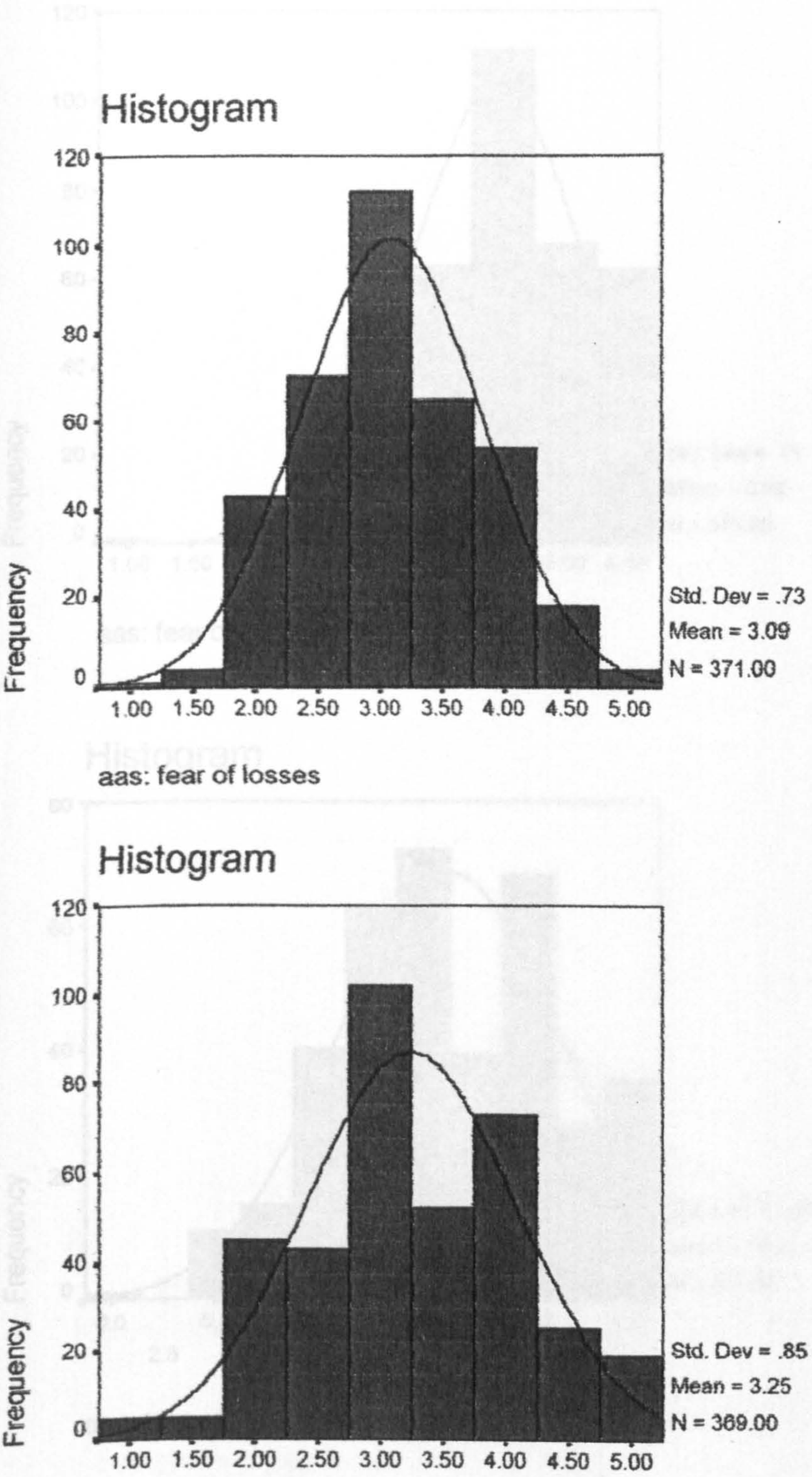
9. More Assistant Psychology (AP) posts
[higher quality AP posts with good supervision, positive experiences as APs]
"more experience as assistant psychologists at a higher level of quality"
"encourage AP posts - rewarding and interesting in the area"
"recruit more people at the pre-training course level e.g. APs"

11. Making services more psychological/less medicalised
"less medicalisation of older adult services"
"where the emphasis on the 'medical model' is balanced more equally with psychological models"
"by psychology services becoming more independent of psychiatry"

Miscellaneous

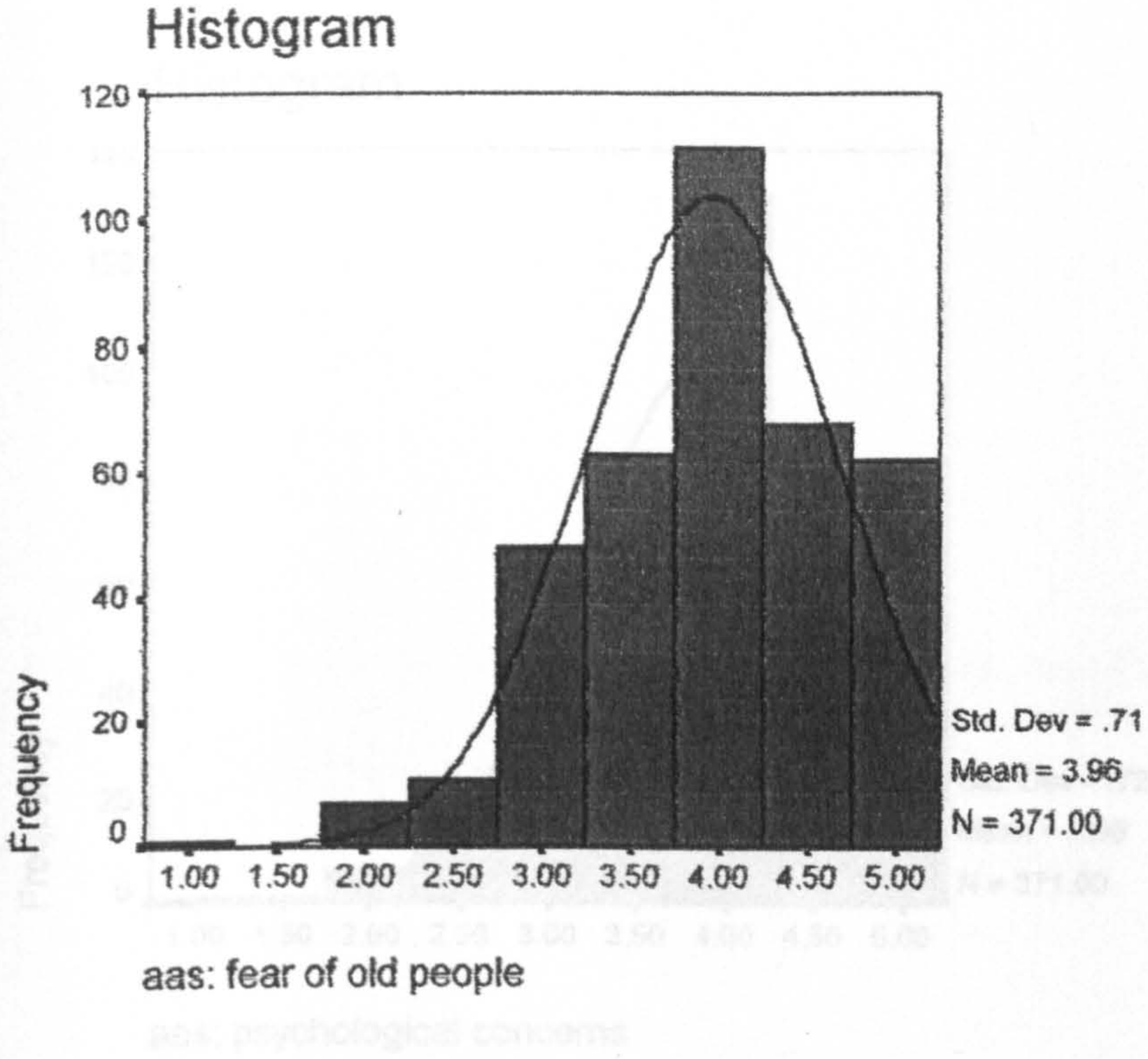
Missing

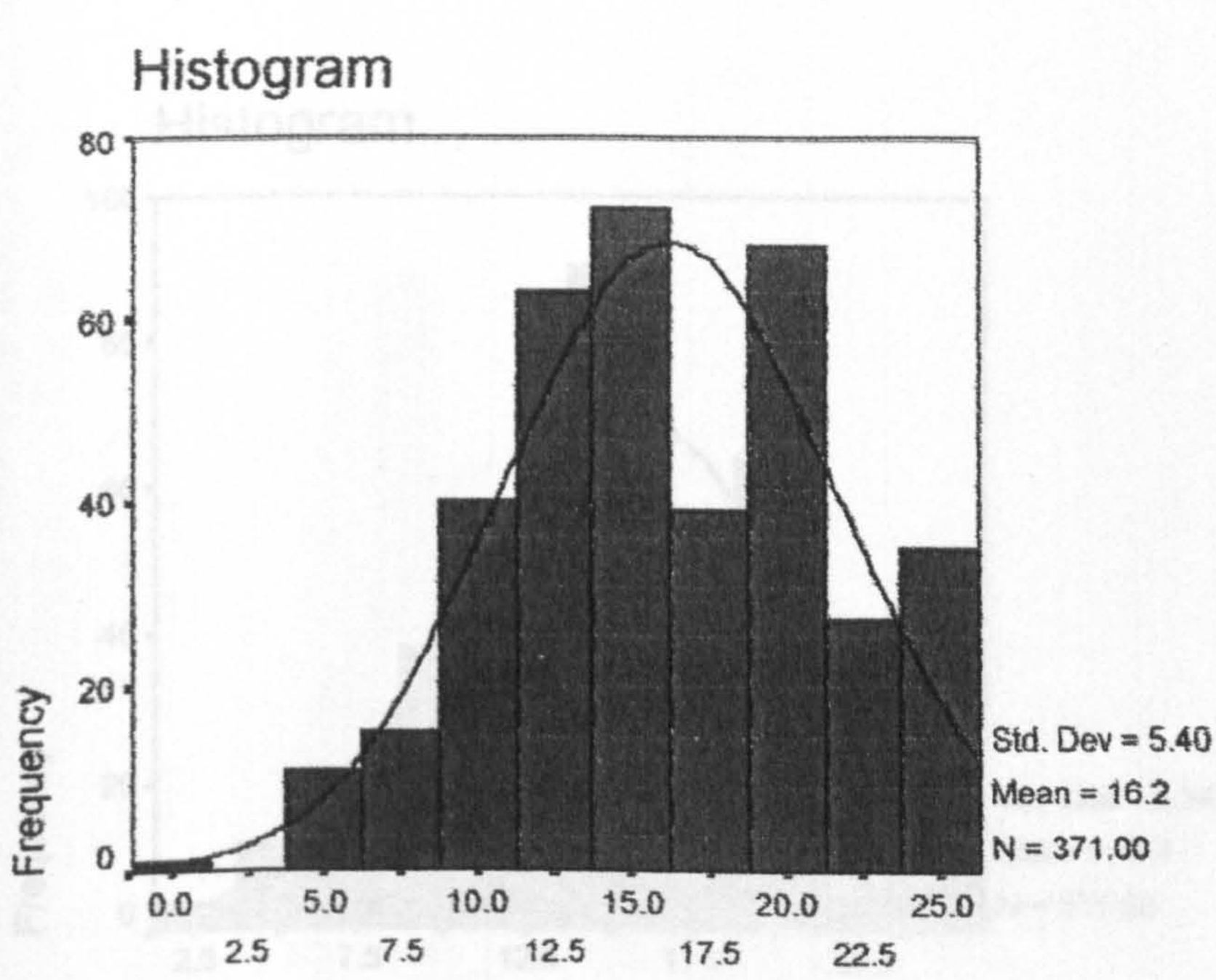
Distributions and data transformations for variables entered into multiple regressions

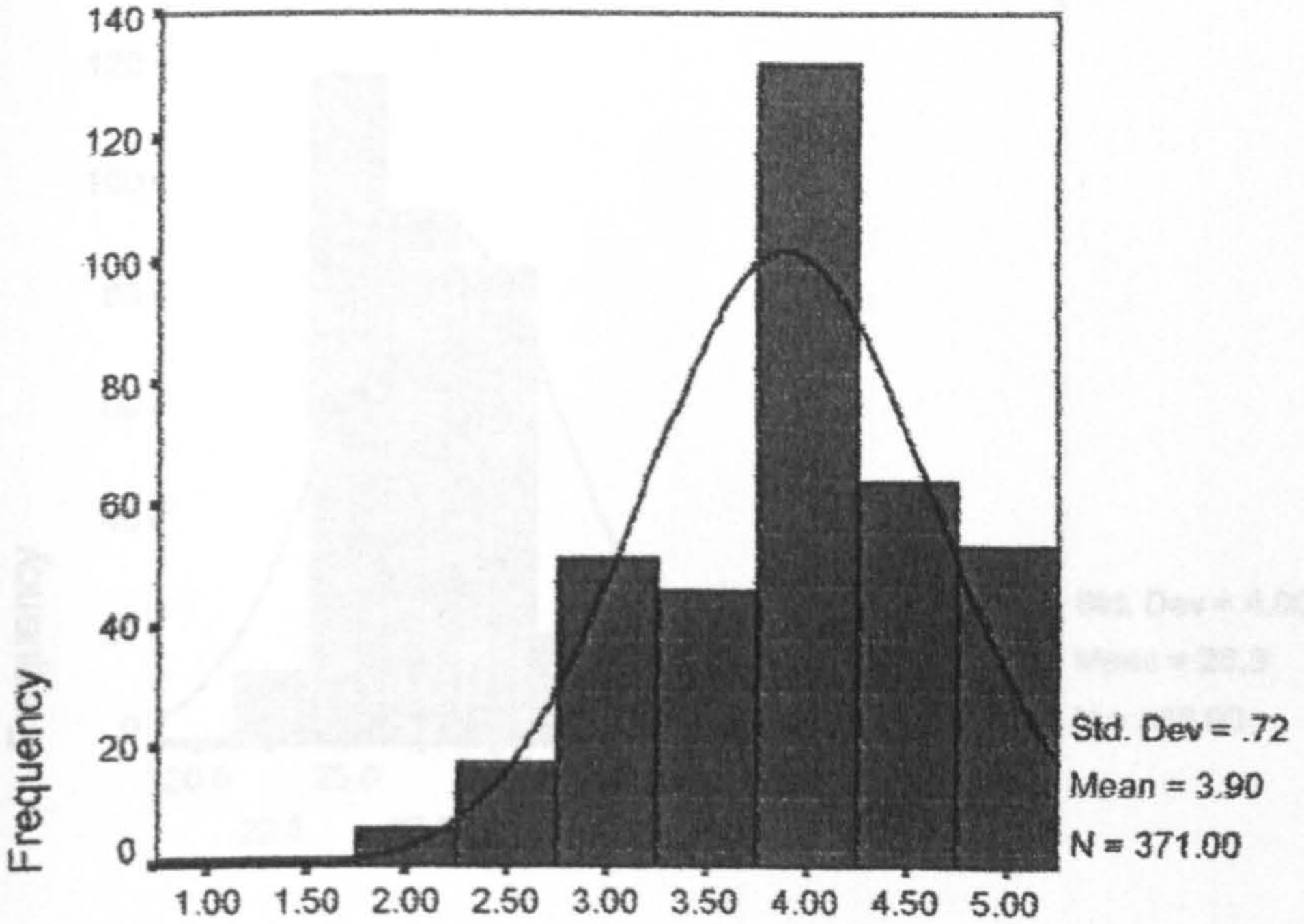


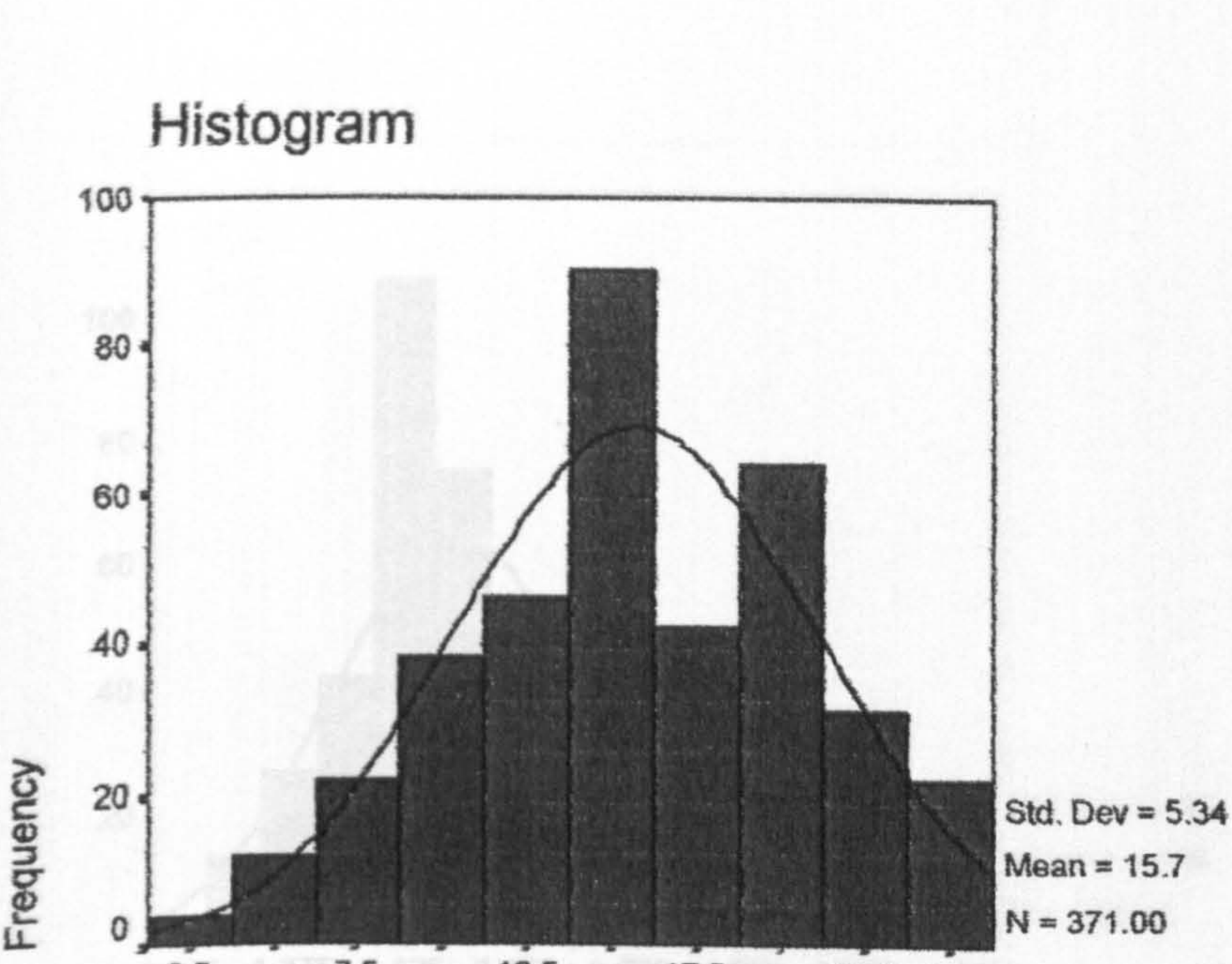
aas: fear of losses

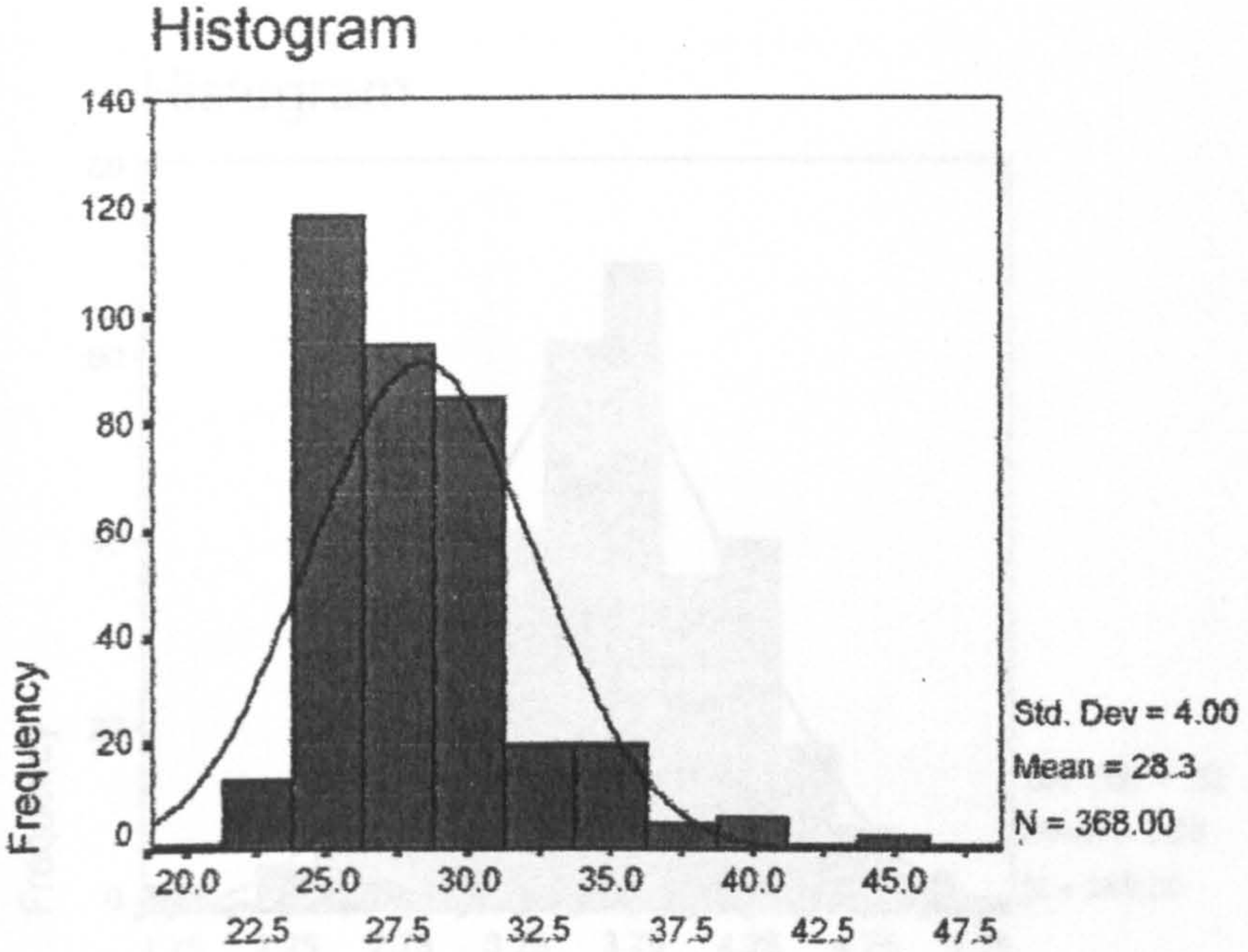
aas: physical appearance

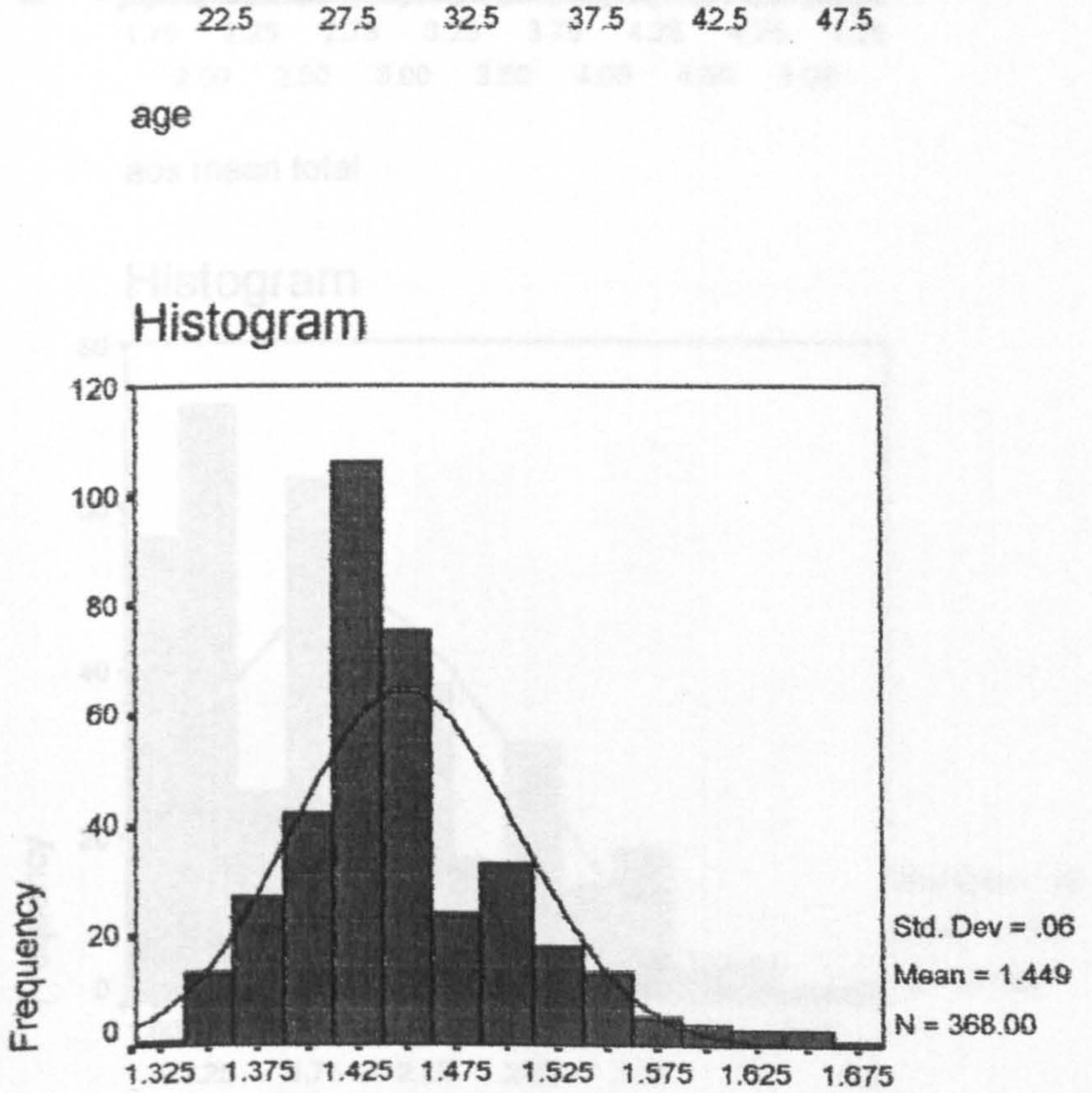

Histogram
120
100
80
60
40
20
0
Frequency
1.00
1.50
2.00
2.50
3.00
3.50
4.00
4.50
5.00
Std. Dev = .71
Mean = 3.96
N = 371.00
aas: fear of old people


Histogram
80
60
40
20
0
Frequency
0.0
2.5
5.0
7.5
10.0
12.5
15.0
17.5
20.0
22.5
25.0
Std. Dev = 5.40
Mean = 16.2
N = 371.00
aas: fear of old people (transformed)

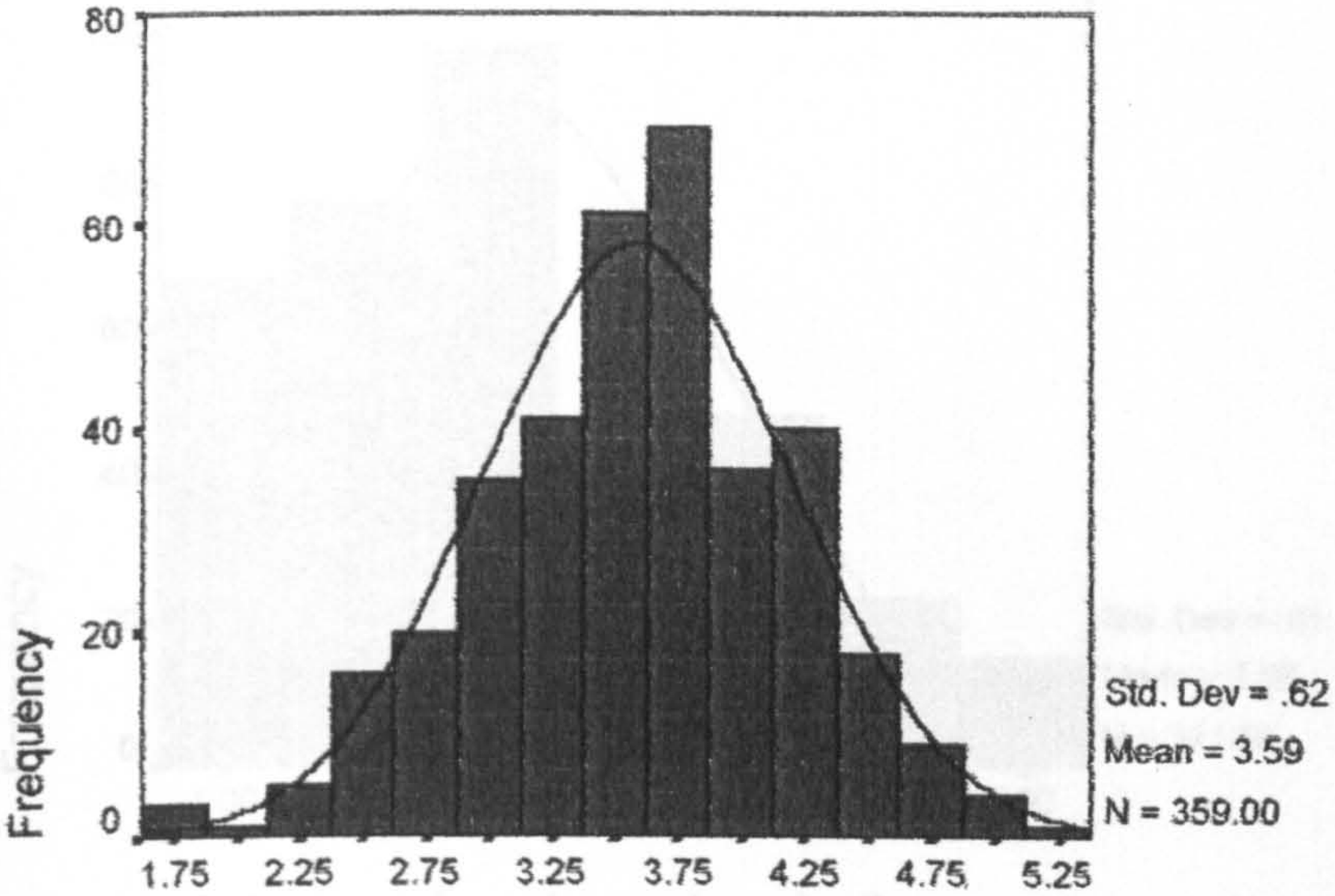

Histogram
140
120
100
80
60
40
20
0
Frequency
Std. Dev = .72
Mean = 3.90
N = 371.00
1.00
1.50
2.00
2.50
3.00
3.50
4.00
4.50
5.00
aas: psychological concerns


Histogram
100
80
60
40
20
0
Frequency
Std. Dev = 5.34
Mean = 15.7
N = 371.00
2.5
7.5
12.5
17.5
22.5
5.0
10.0
15.0
20.0
25.0
aas: psychological concerns (transformed)


Histogram
140
120
100
80
60
40
20
0
Frequency
20.0
25.0
30.0
35.0
40.0
45.0
22.5
27.5
32.5
37.5
42.5
47.5
Std. Dev = 4.00
Mean = 28.3
N = 368.00
age

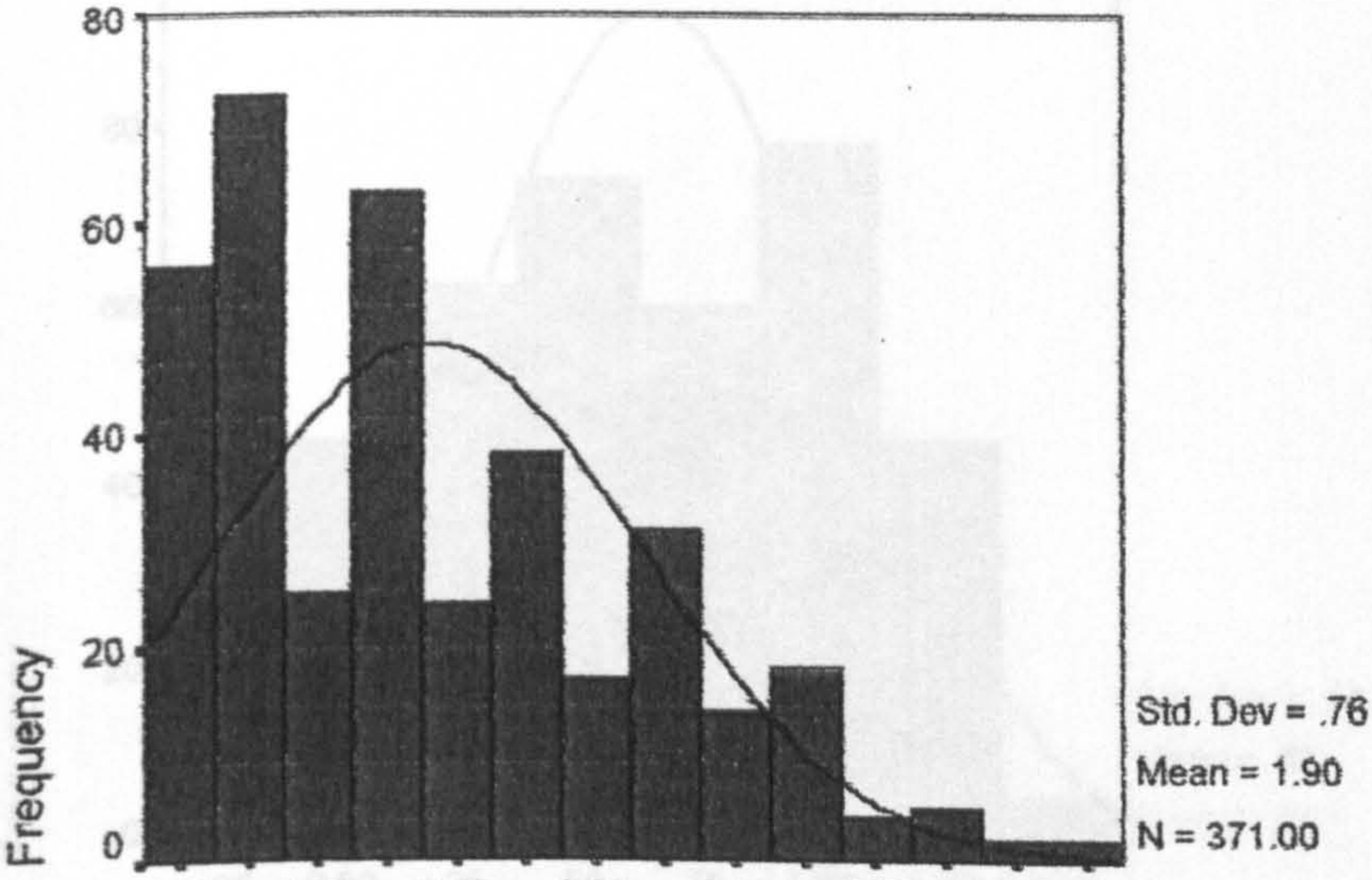

Histogram
120
100
80
60
40
20
0
Frequency
1.325
1.375
1.425
1.475
1.525
1.575
1.625
1.675
1.350
1.400
1.450
1.500
1.550
1.600
1.650
Std. Dev = .06
Mean = 1.449
N = 368.00
age (transformed)

Histogram

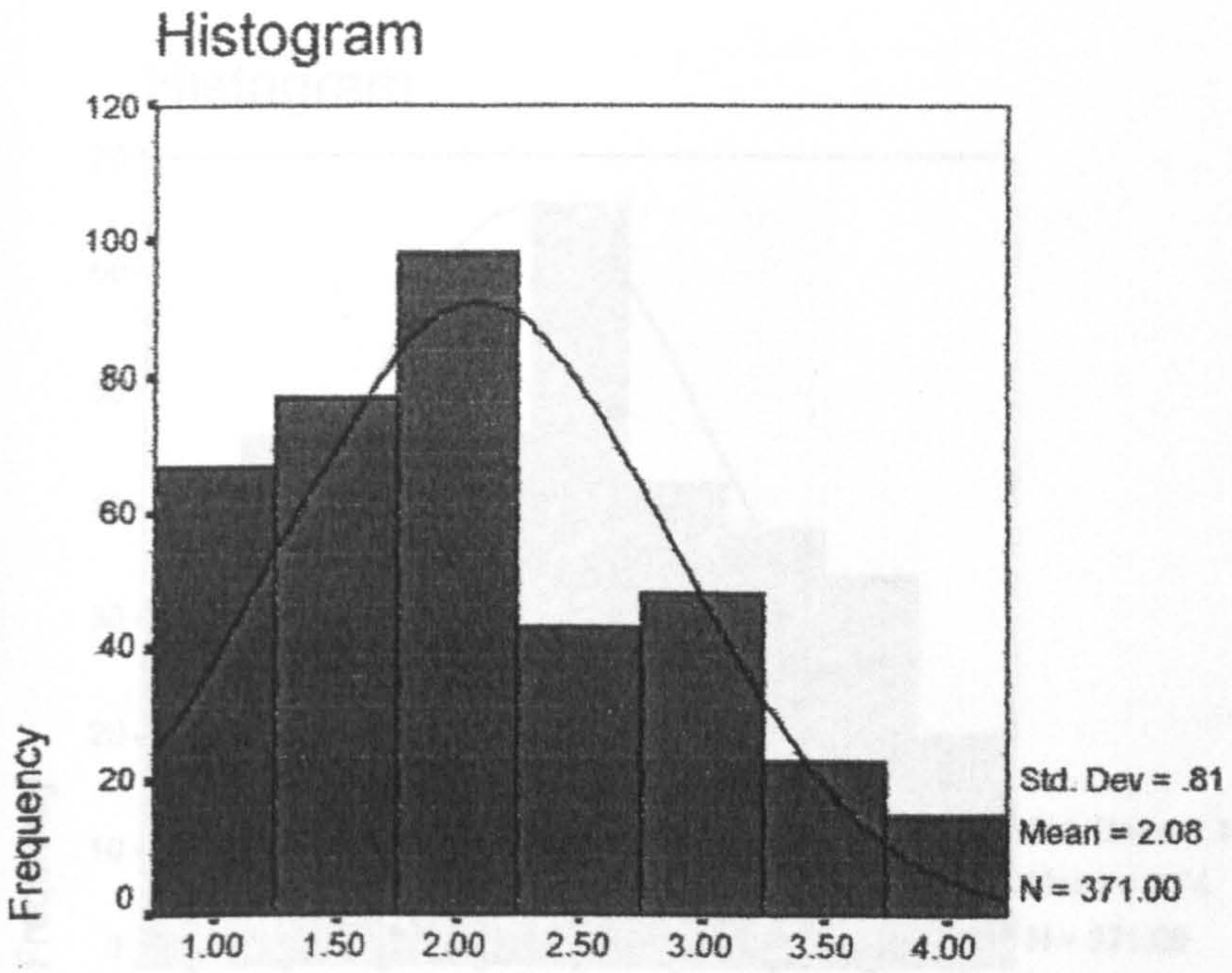


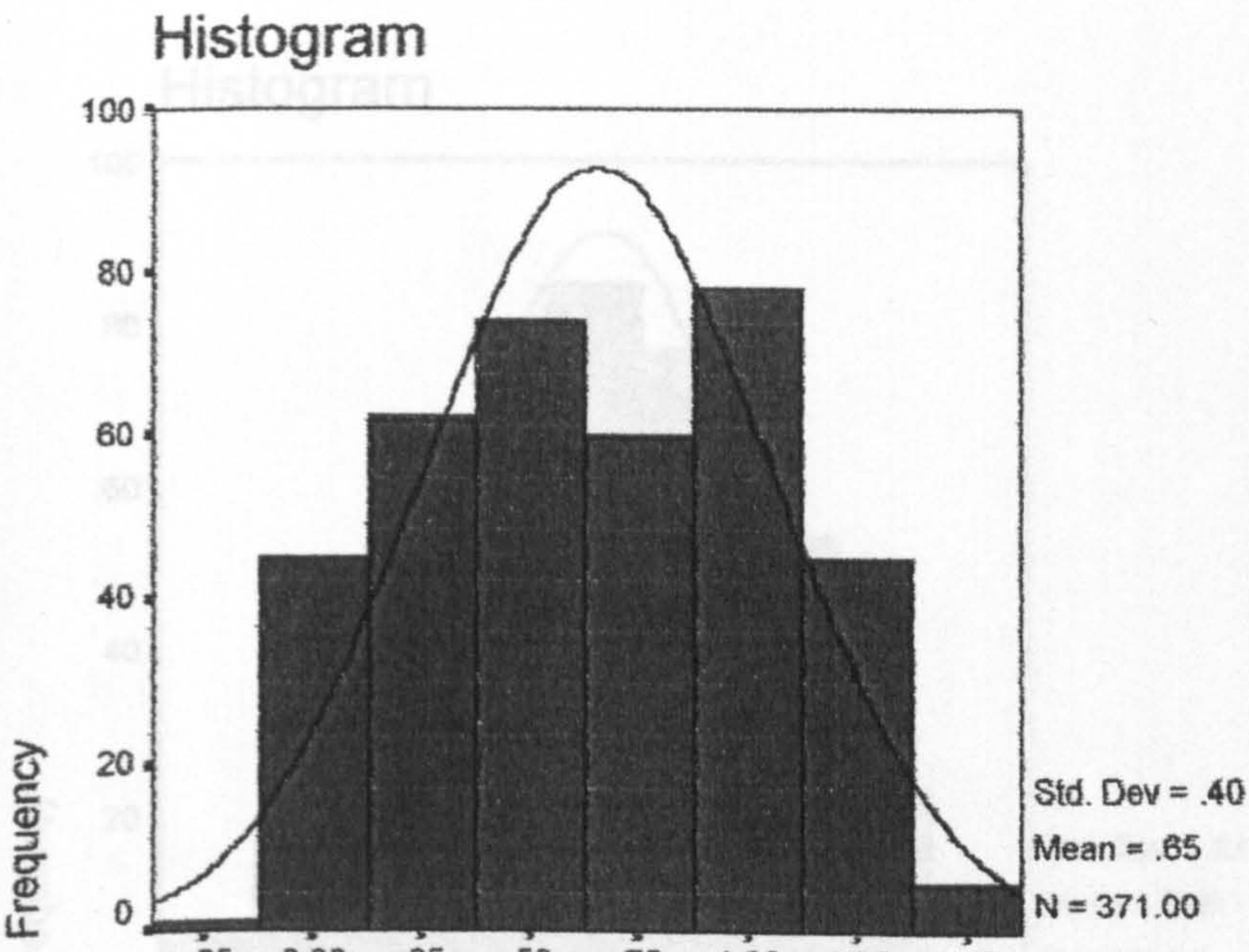
aos mean total

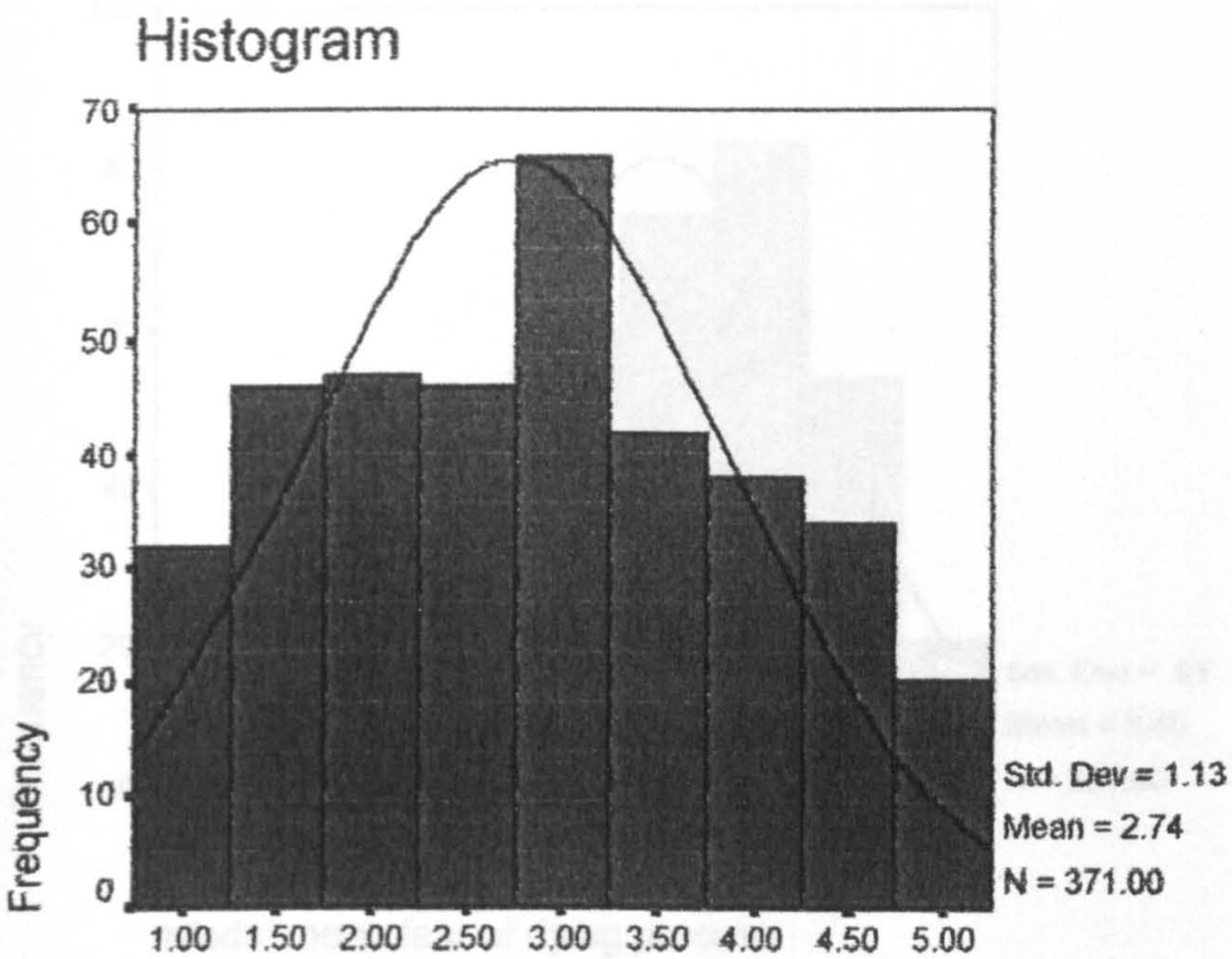
Histogram



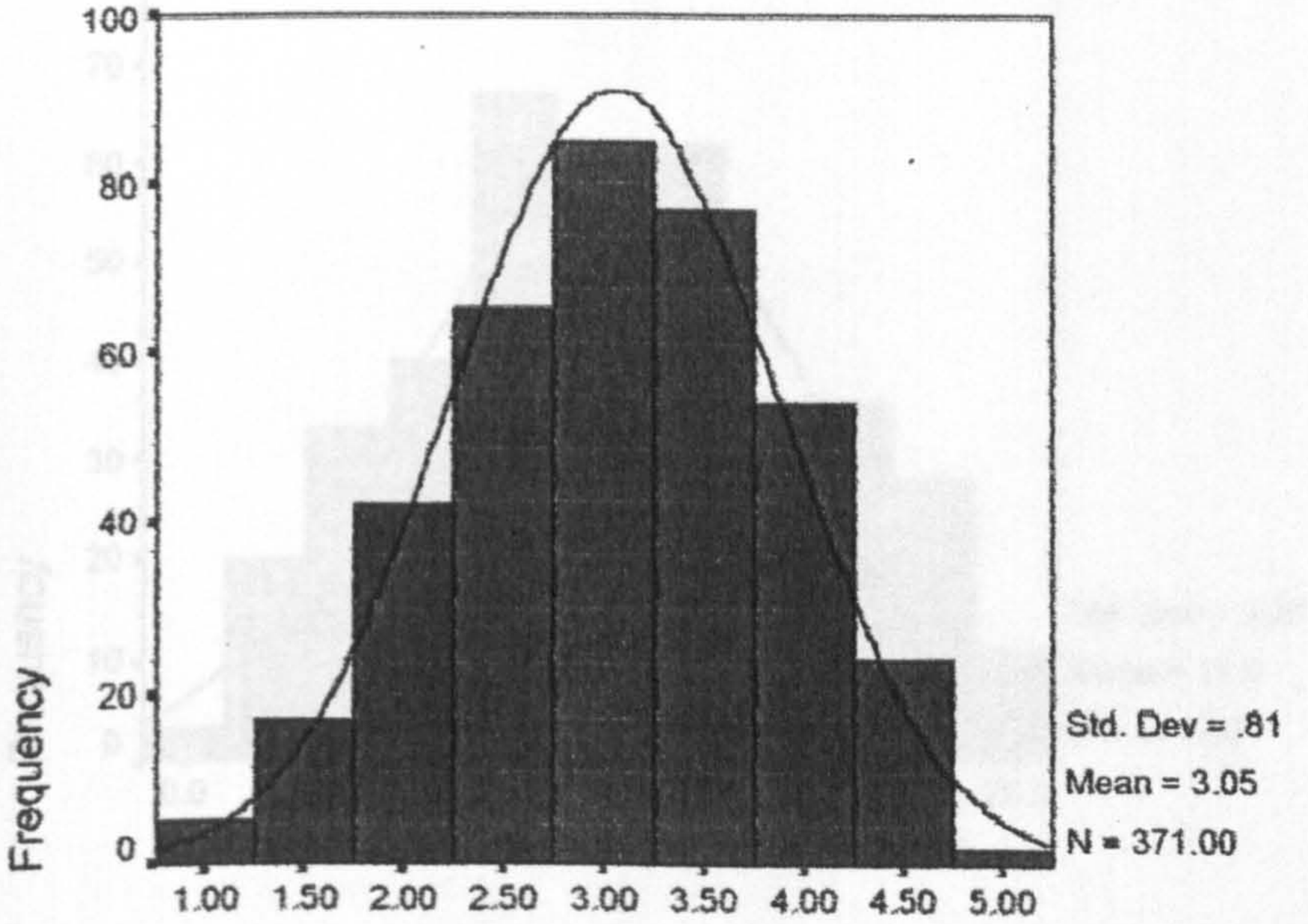
mfods: mean fear for the body after death


Histogram
120
100
80
60
40
20
0
Frequency
Std. Dev = .81
Mean = 2.08
N = 371.00
1.00
1.50
2.00
2.50
3.00
3.50
4.00
mfods: mean fear of conscious death


Histogram
100
80
60
40
20
0
Frequency
Std. Dev = .40
Mean = .65
N = 371.00
-.25
0.00
.25
.50
.75
1.00
1.25
1.50
mfods: fear of conscious death (transformed)

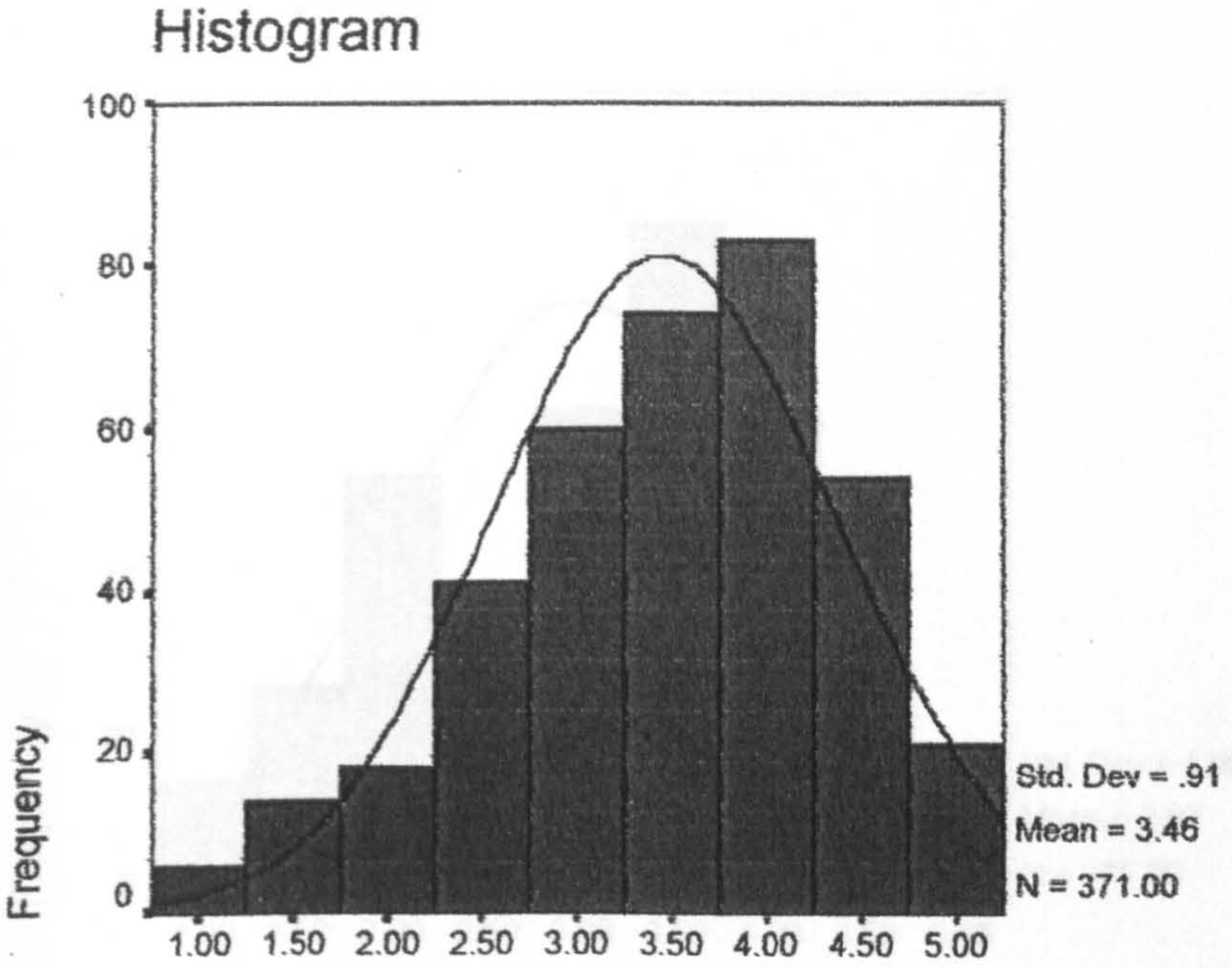


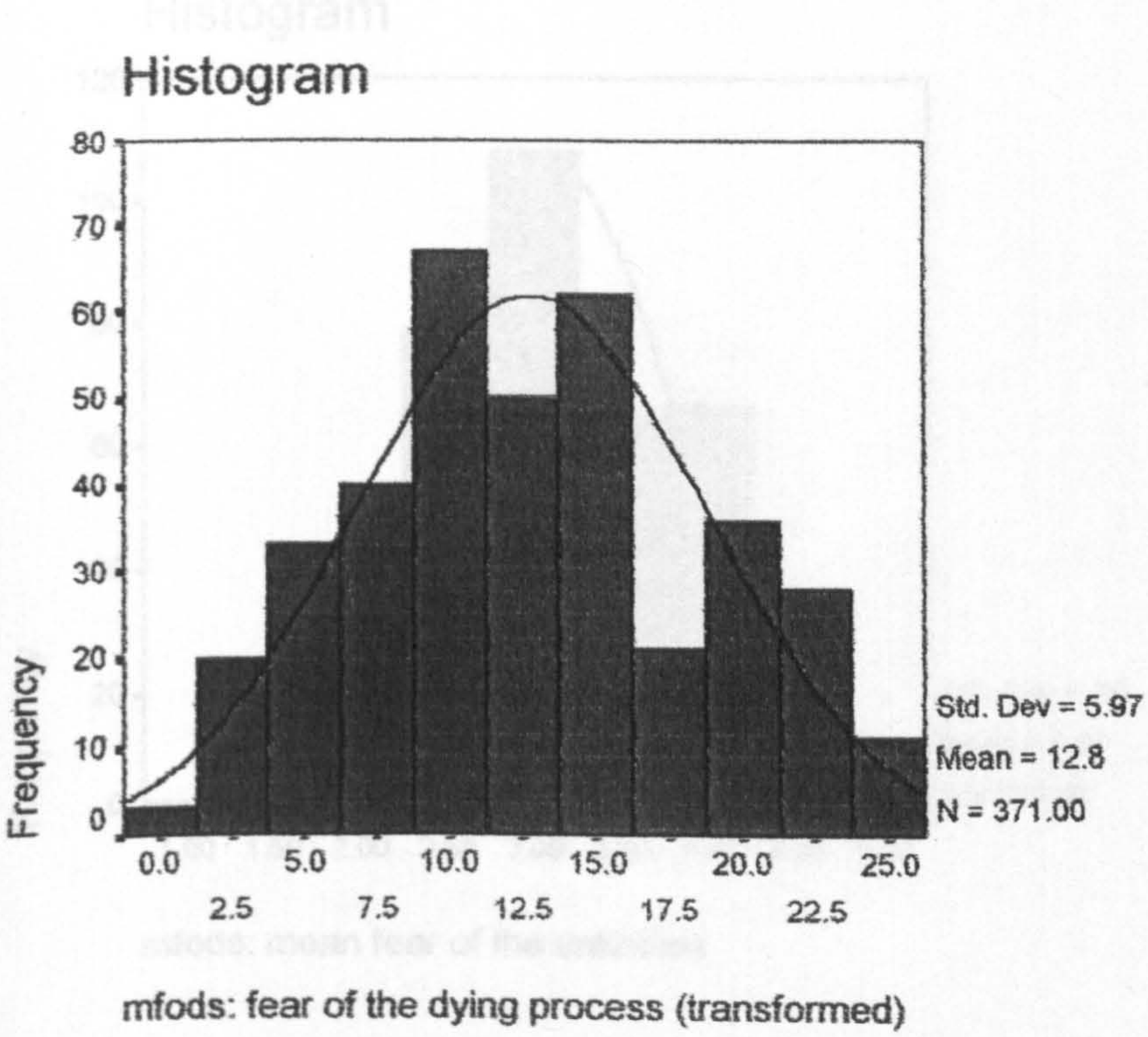
mfods: mean fear of being destroyed



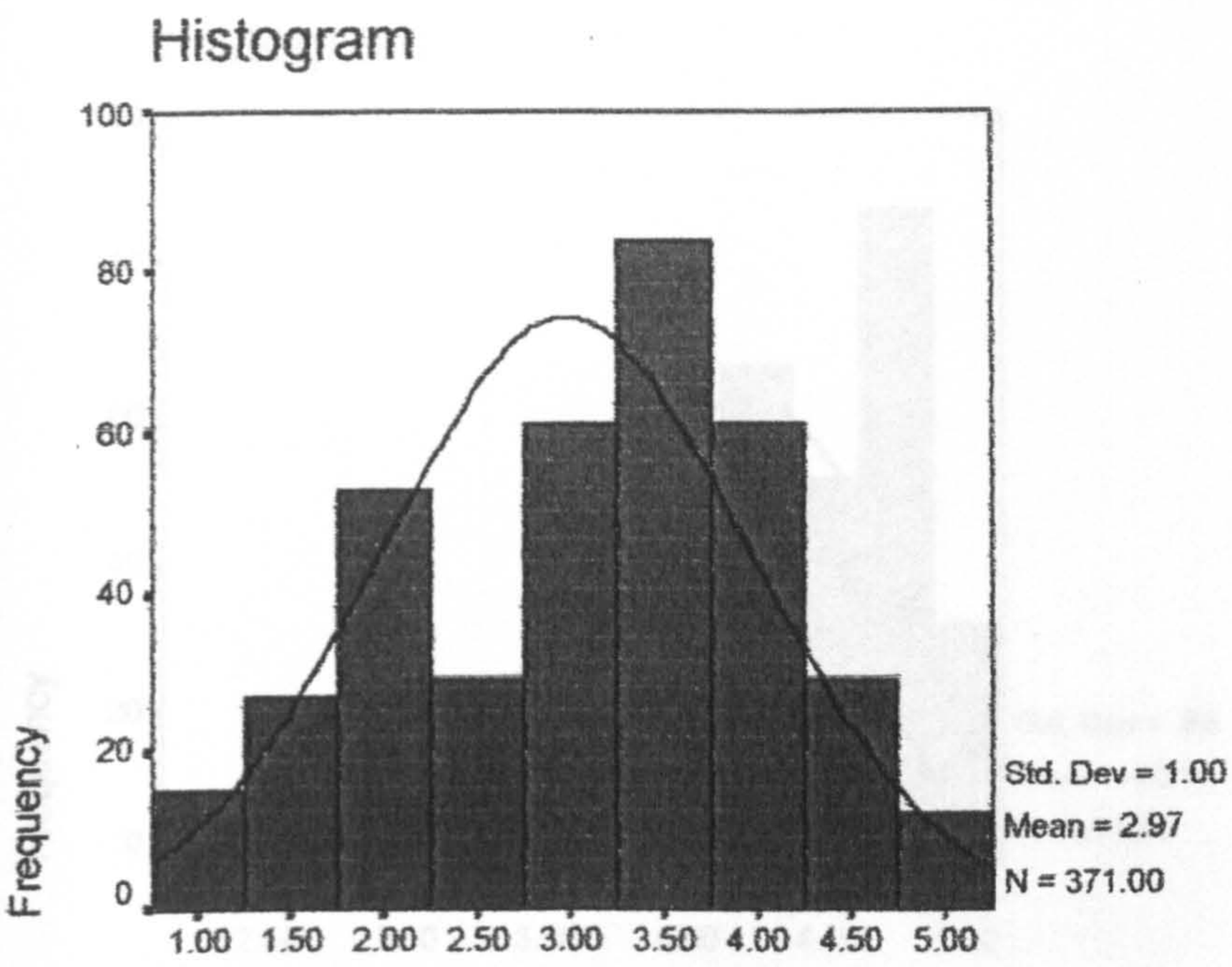
mfods:mean fear of the dead

APPENDIX TWELVE

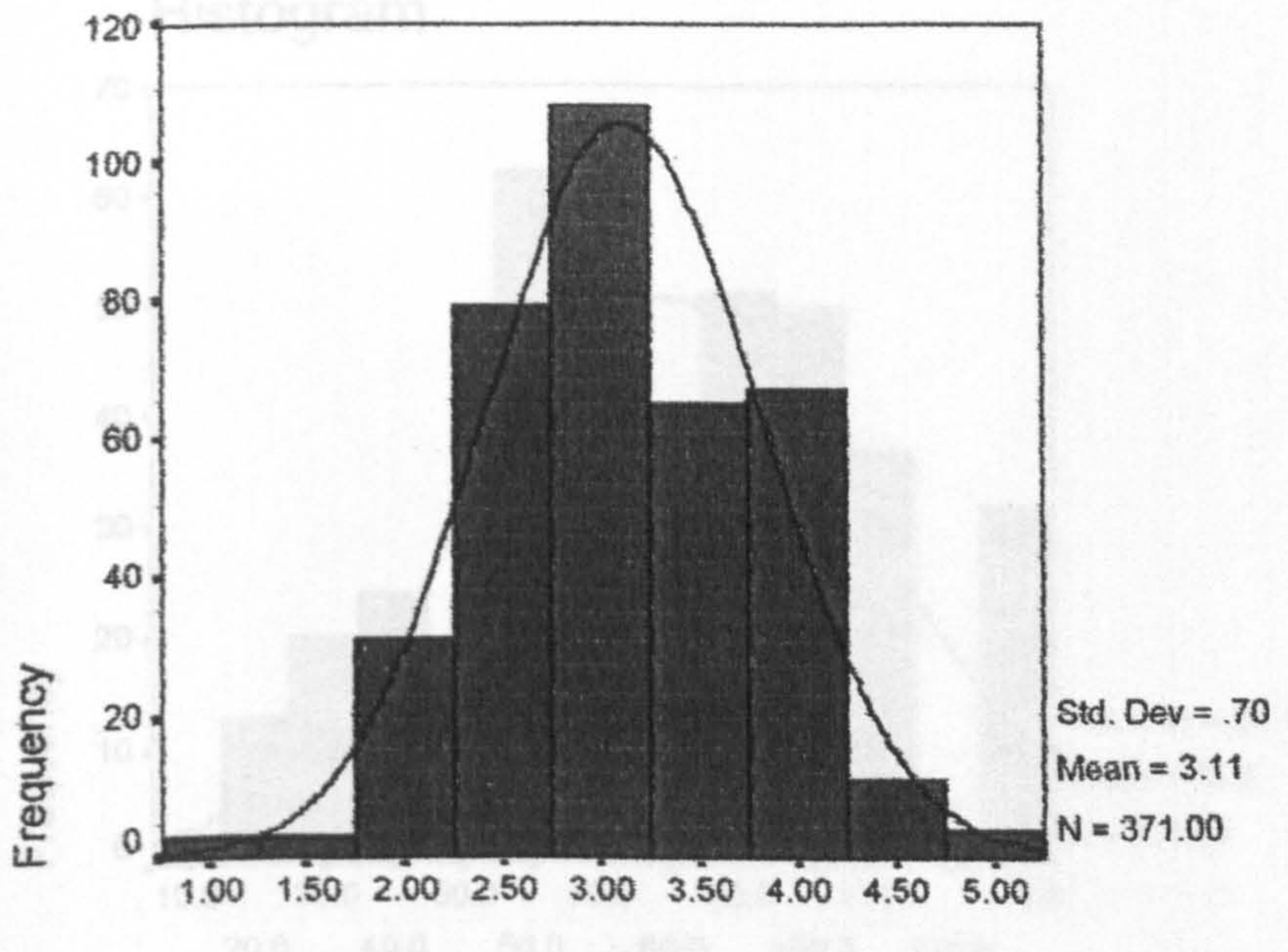




APPENDIX TWELVE

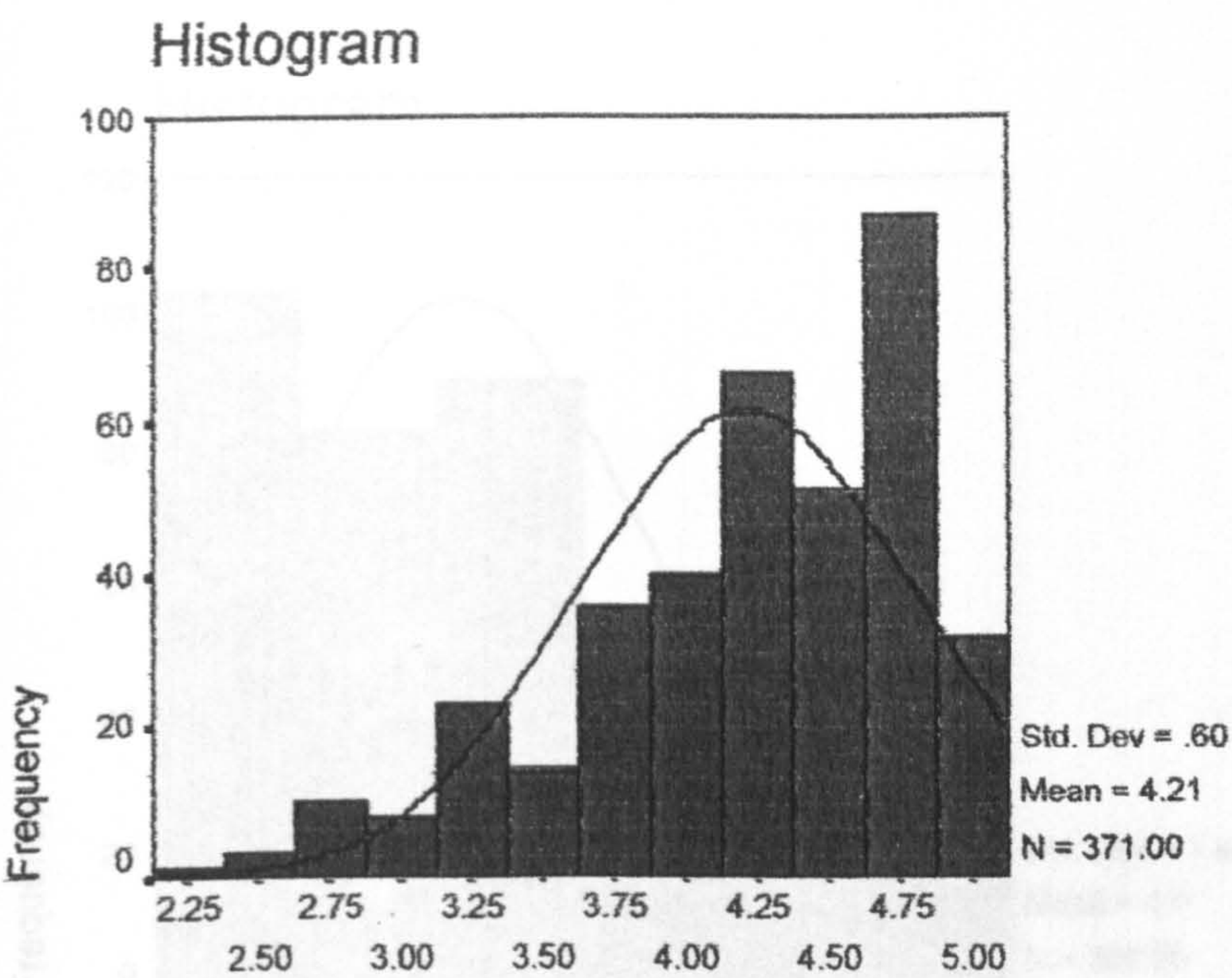


mfods: mean fear of premature death

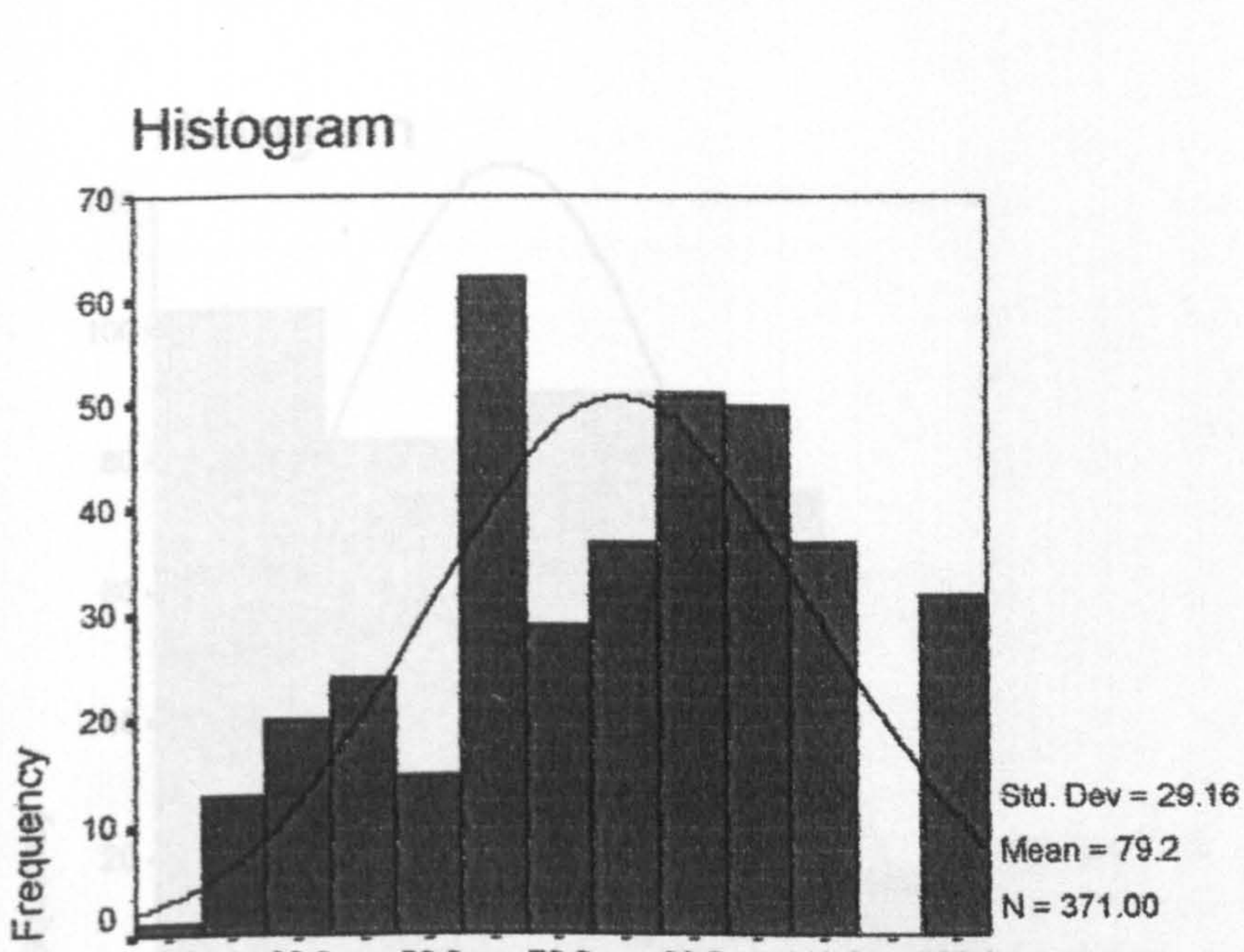


mfods: mean fear of the unknown

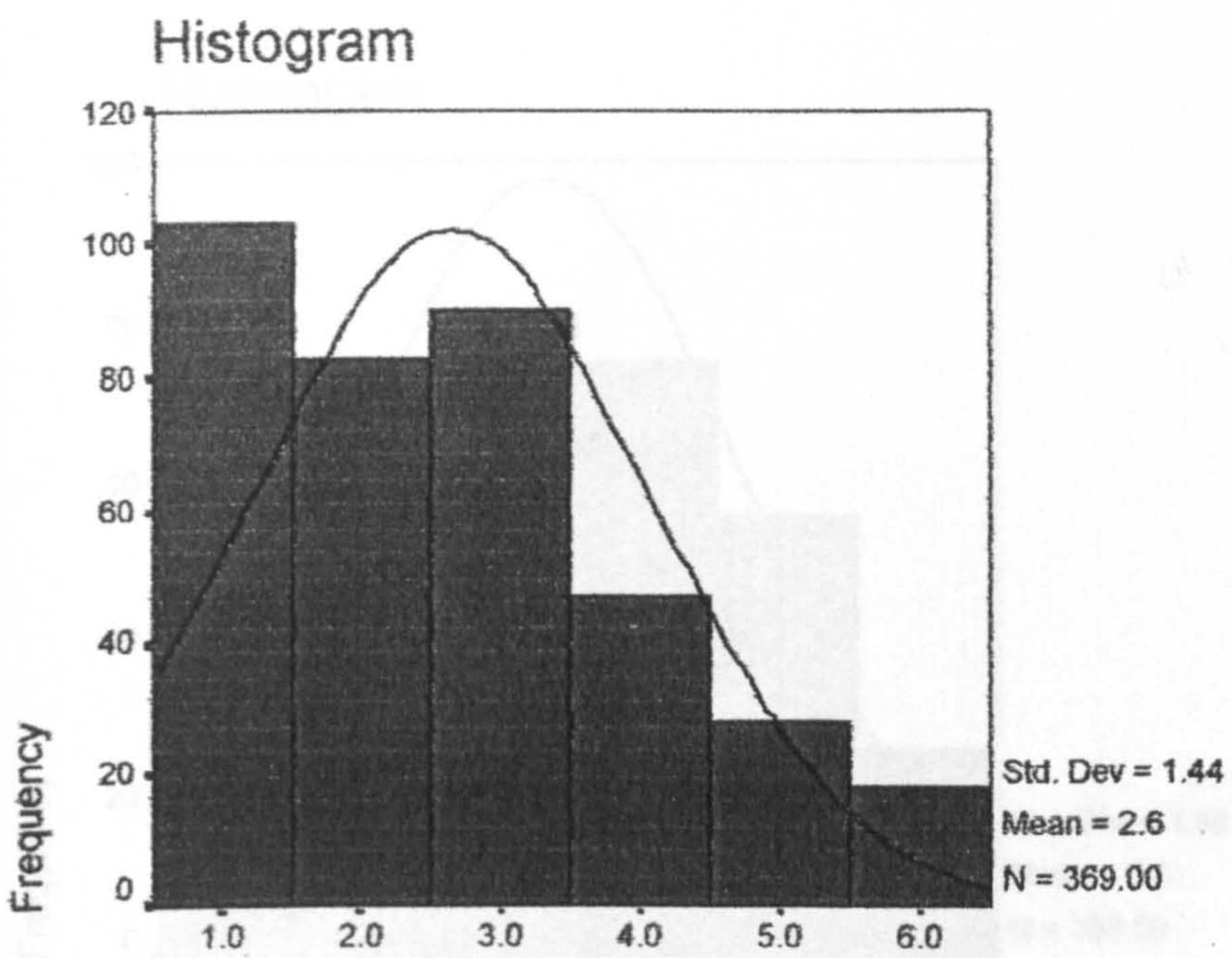
APPENDIX TWELVE



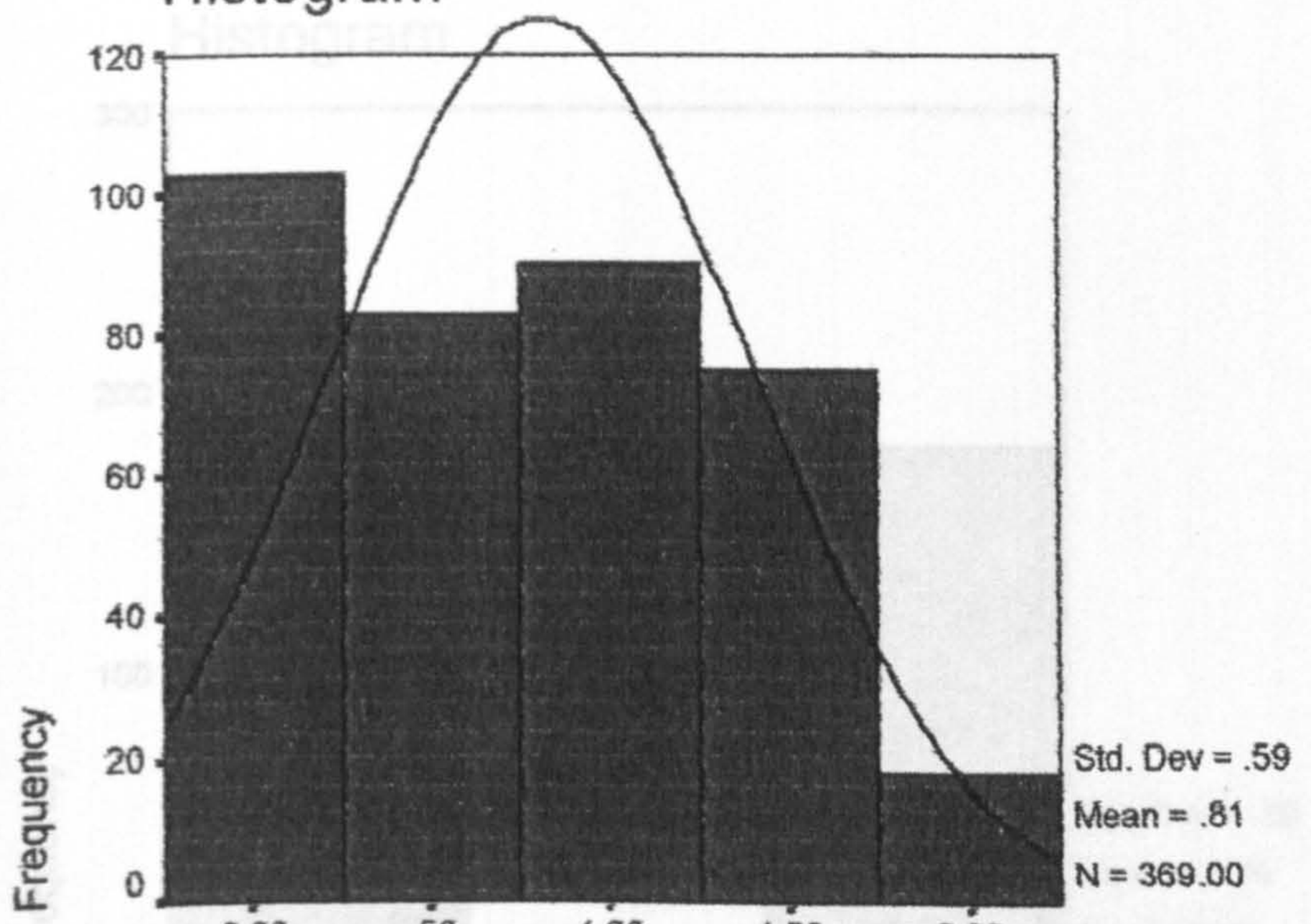
mfods: mean fear of significant others



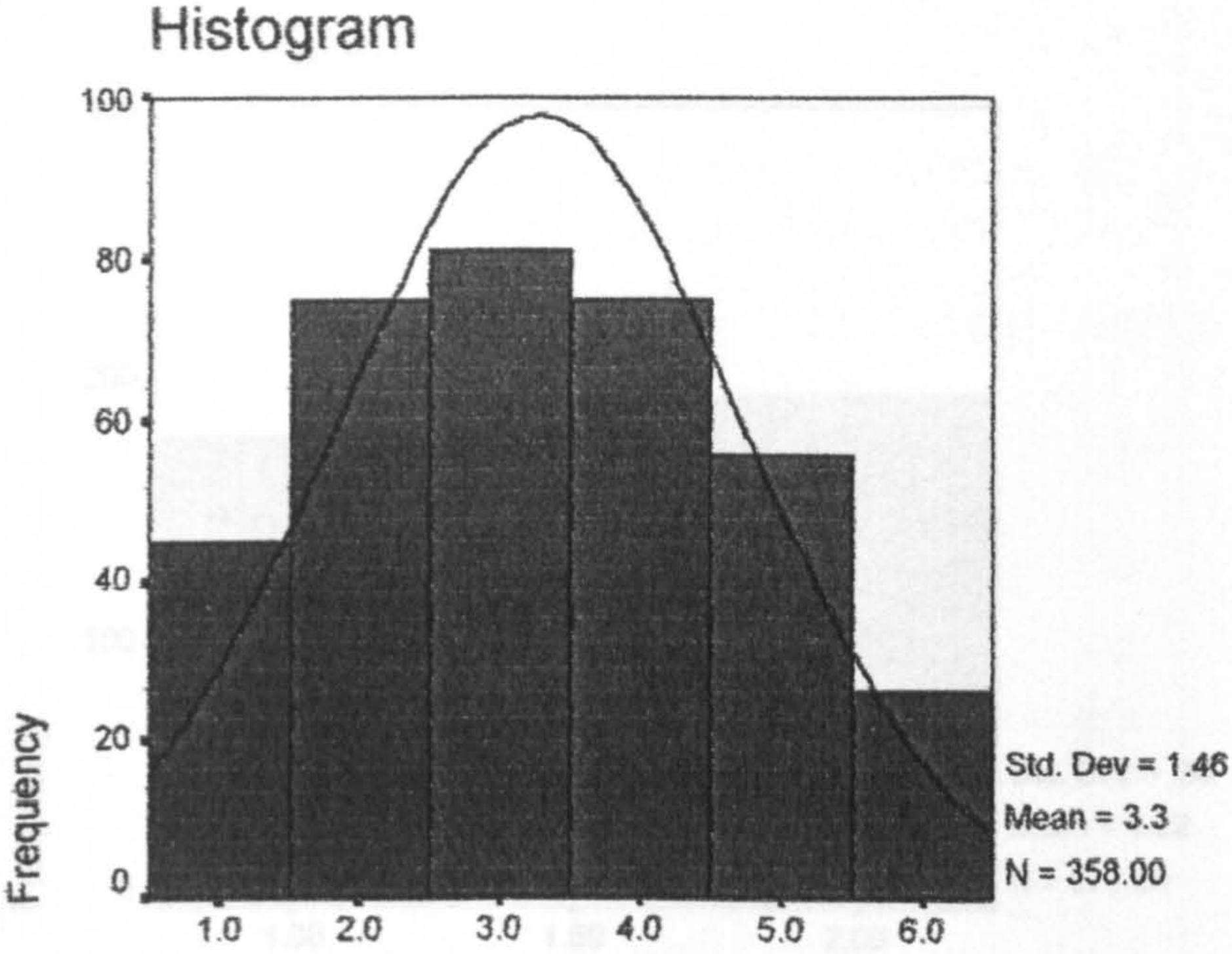
mfods: fear for significant others (transformed)

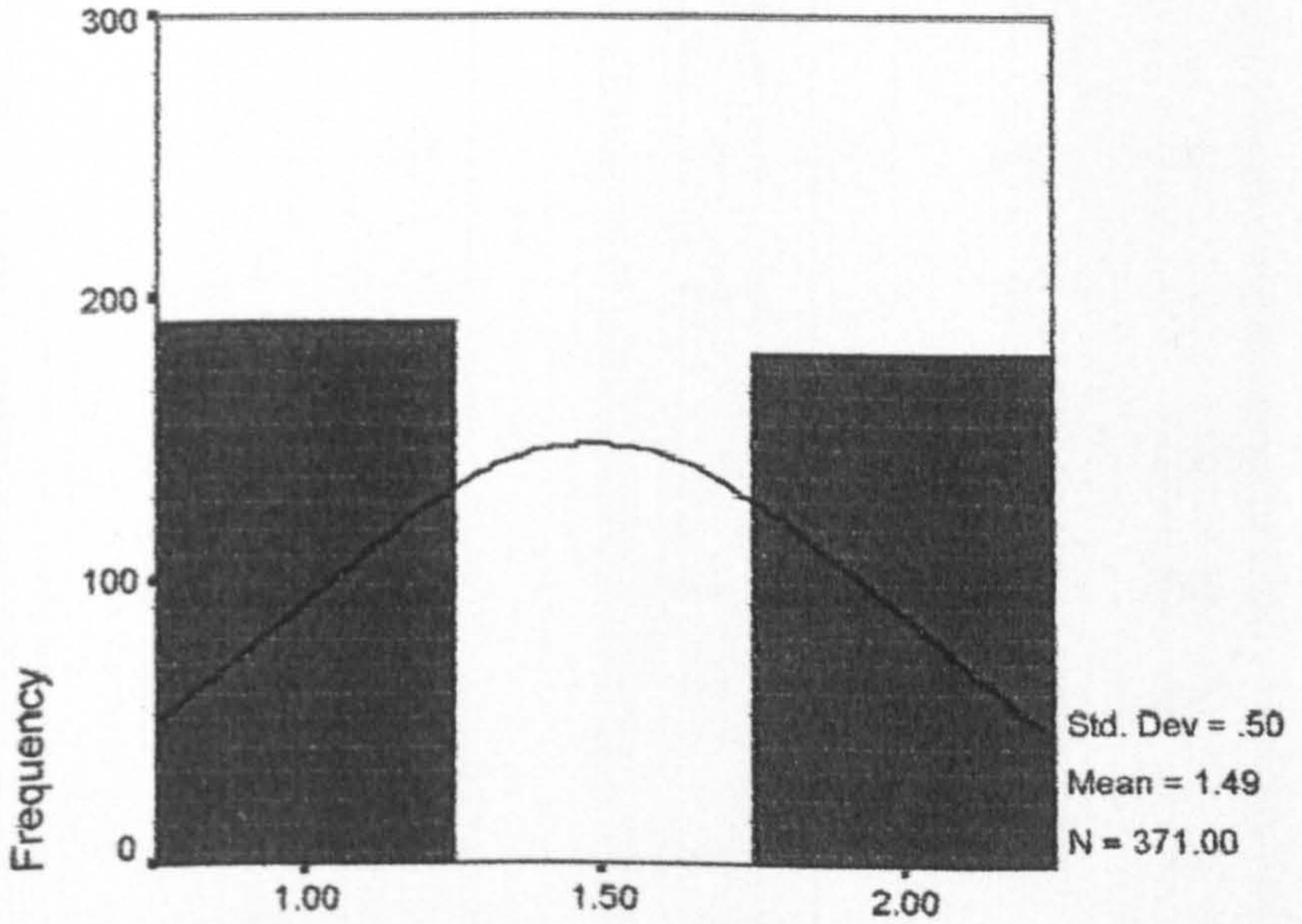


desire to work with older adults prior to training

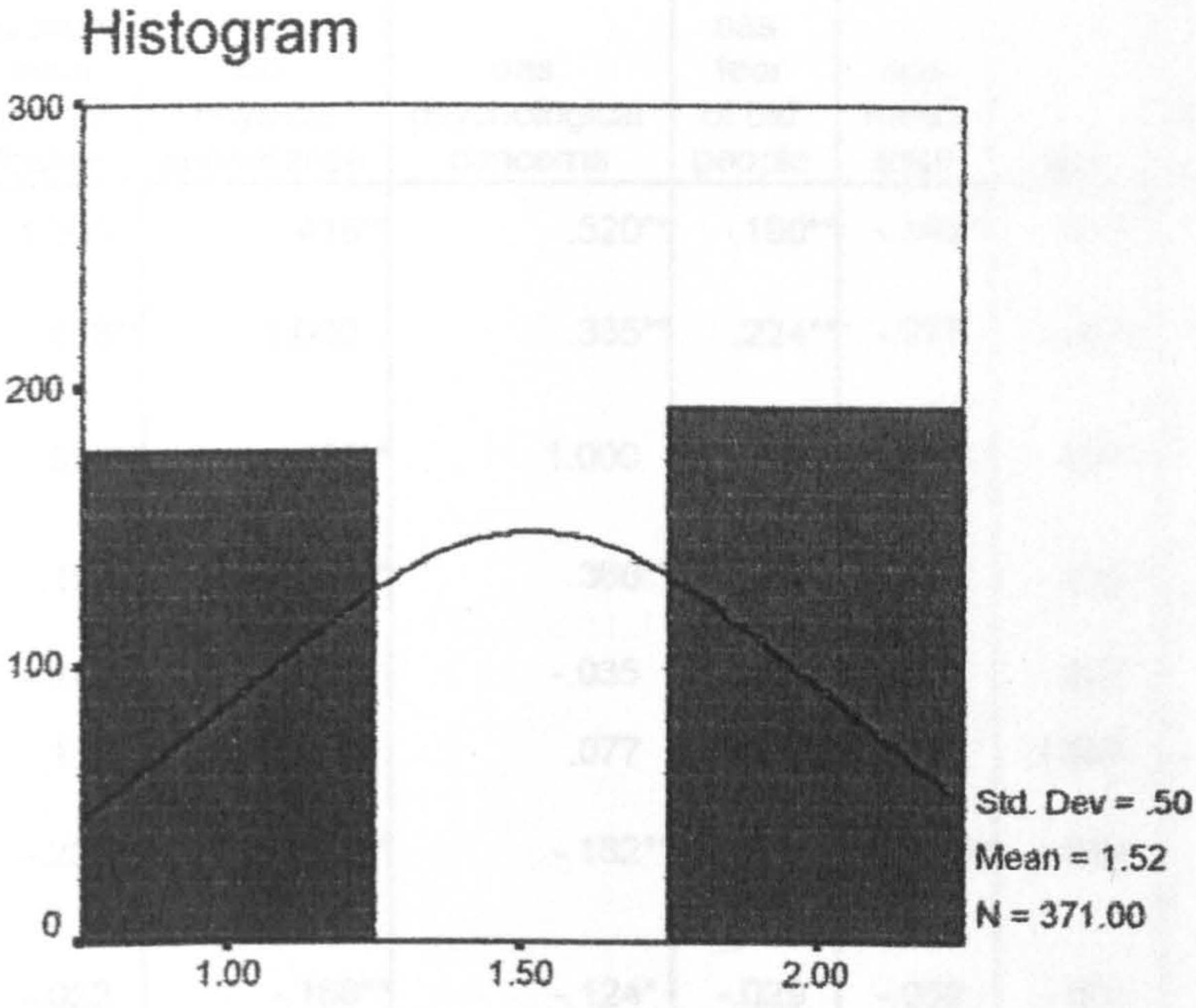


desire to work with older aults prior to training (transformed)


Histogram
100
80
60
40
20
0
Frequency
Std. Dev = 1.46
Mean = 3.3
N = 358.00
1.0
2.0
3.0
4.0
5.0
6.0
current interest in working with older people


Histogram
300
200
100
0
Frequency
Std. Dev = .50
Mean = 1.49
N = 371.00
1.00
1.50
2.00
older adult placement experience

APPENDIX TWELVE



APPENDIX THIRTEEN

Pearson Correlations

	anxiety :mean fear of losses	aas: physical appearance	aas: psychological concerns	aas: fear of old people	aos mean total	age	mfods: fear of conscious death	mfods: mean fear of being destroyed
anxiety:mean fear of losses	1.000	.418**	.520**	.190**	-.149**	.119*	-.237**	-.032
aas: physical appearance	.418**	1.000	.385**	.224**	-.017	-.060	-.142**	-.168**
aas: psychological concerns	.520**	.385**	1.000	.366**	-.035	.077	-.182**	-.124*
aas: fear of old people	.190**	.224**	.366**	1.000	.062	-.032	.073	-.029
aos mean total	-.149**	-.017	-.035	.062	1.000	-.047	.229**	-.052
age	.119*	-.060	.077	-.032	-.047	1.000	-.044	-.001
mfods: fear of conscious death	-.237**	-.142**	-.182**	.073	.229**	-.044	1.000	.180**
mfods: mean fear of being destroyed	-.032	-.168**	-.124*	-.029	-.052	-.001	.180**	1.000
mfods: fear of the dying process	-.400**	-.231**	-.169**	.004	.088	-.132*	.478**	.121*
mfods: mean fear of premature death	-.416**	-.260**	-.230**	-.079	.064	-.109*	.223**	.098
mfods: fear for significant others	-.197**	-.263**	-.133*	.015	-.048	-.231**	.087	.049
mfods: mean fear of the unknown	-.270**	-.280**	-.224**	-.082	.019	-.037	.215**	.166**
desire to work with older adults prior to training	.008	.098	.074	.319**	.007	.095	.067	.050
older adult	-.002	.125*	.090	.370**	-.027	.090	.069	.068
older adult placement experience	.072	.058	.027	.035	-.089	.096	-.096	.039
pre training older adult work experience	.051	-.033	-.021	-.177**	.044	-.074	-.086	-.034

Pearson Correlations

	mfods: fear of the dying process	mfods: mean fear of premature death	mfods: fear for significant others	mfods: mean fear of the unknown	desire to work with older adults prior to training	older adult	older adult placement experience	pre training older adult work experience
anxiety:mean fear of losses	-.400**	-.416**	-.197**	-.270**	.008	-.002	.072	.051
aas: physical appearance	-.231**	-.260**	-.263**	-.280**	.098	.125*	.058	-.033
aas: psychological concerns	-.169**	-.230**	-.133*	-.224**	.074	.090	.027	-.021
aas: fear of old people	.004	-.079	.015	-.082	.319**	.370**	.035	-.177**
aos mean total	.088	.064	-.048	.019	.007	-.027	-.089	.044
age	-.132*	-.109*	-.231**	-.037	.095	.090	.096	-.074
mfods: fear of conscious death	.478**	.223**	.087	.215**	.067	.069	-.096	-.086
mfods: mean fear of being destroyed	.121*	.098	.049	.166**	.050	.068	.039	-.034
mfods: fear of the dying process	1.000	.482**	.302**	.241**	-.014	-.019	-.107*	-.115*
mfods: mean fear of premature death	.482**	1.000	.328**	.327**	.040	.032	.019	-.074
mfods: fear for significant others	.302**	.328**	1.000	.223**	-.027	-.052	-.077	.017
mfods: mean fear of the unknown	.241**	.327**	.223**	1.000	-.028	-.005	-.048	-.014
desire to work with older adults prior to training	-.014	.040	-.027	-.028	1.000	.536**	-.110*	-.444**
older adult	-.019	.032	-.052	-.005	.536**	1.000	.097	-.297**
older adult placement experience	-.107*	.019	-.077	-.048	-.110*	.097	1.000	.079
pre training older adult work experience	-.115*	-.074	.017	-.014	-.444**	-.297**	.079	1.000

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).